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Influential Factors in the Development and Maintenance of Eating Disorders

by

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Declaration

This thesis was carried out under the supervision of Dr David Giles, who helped with the design of the study and gave advice during the analysis and write-up stages of the research and Dr Wendy Phillips who provided access to participants. I carried out all of the interviews and apart from these collaborations this thesis is my own work. I also received support from other trainees in the form of a Grounded Theory Group.

Authorship of any papers from this work will be shared with the above named supervisors. This thesis has not been, and will not be, submitted for a degree at any other university. The literature review is being prepared for submission to the European Eating Disorder Review (Peters and Giles, in preparation), the main paper is being prepared for submission to the British Journal of Clinical Psychology (Peters, Giles and Phillips, in preparation), the brief paper is being prepared for the International Journal of Eating Disorders (Peters, Giles and Phillips, in preparation) and the reflective paper is being prepared for Clinical Psychology (Peters, in preparation). Notes for contributors for each of these journals can be seen in appendices A, B, C and D respectively.

Summary

This thesis examined influential factors in the development and maintenance of eating disorders. The first chapter investigated homosexuality as a predisposing factor in the development of anorexia and bulimia nervosa in males by considering the published literature on this subject. The implications of the role of homosexual culture in the treatment of males with eating disorders are examined.

The main study used techniques from grounded theory to examine the subjective experiences of women with anorexia and bulimia nervosa regarding the influence of media in the development and maintenance of their disorder. Semi-structured interviews were conducted with nine women and data collection and analysis were carried out until a point of saturation was reached. A model was developed to explain the relationship between media influence and eating disorder development and maintenance. Clinical implications and avenues of further research were explored.

The brief paper examined the stories of women with anorexia and bulimia nervosa about the development of their eating disorder using narrative analysis techniques. Three semi-structured interviews were analysed and the ways in which the women made sense of their eating disorders were examined. Clinical implications were also discussed.

The final chapter explored the researcher's reflections on the research process focusing on methodological considerations and personal reflections of the researcher.

Chapter One

Homosexuality as a Predisposing Factor for Anorexia Nervosa in Males: A Review of the Literature

Abstract

Eating disorders are more common in females than males, although over recent years interest in males with eating disorders has developed and more research into this area is being carried out. There is some evidence that male and female eating disordered patients are similar, however some differences have been found. One notable difference is sexual activity and sexual orientation in male and female eating disordered patients. This literature review aims to identify the broad relationship between eating disorders and sexual/gender identity. Homosexual males are over-represented within eating disorder services compared to heterosexual males and studies with non-clinical populations have also suggested a link between homosexuality, body dissatisfaction and eating disordered behaviour. This may be caused by pressure within male homosexual culture for men to be physically attractive. The implications for clinicians working with people with eating disorders based on the literature are discussed.

'Eating disorder' is a term used for problems which are believed to be predominantly psychological in nature and which manifest themselves in unhelpful attitudes and behaviour towards food. The most common eating disorders are anorexia and bulimia nervosa (Polivy and Herman, 2002). The main symptoms of anorexia and bulimia such as body dissatisfaction and preoccupation with food, shape and weight are similar (Polivy and Herman, 2002) and the distinction between the disorders is determined by specific symptomatology being met (Garfinkel, 2002).

Eating disorders are far less common in males than in females (Anderson, 1990; Burns and Crisp, 1985; Ellis and Cantrell, 1985; Hall, Delahunt and Ellis, 1985; Herzog, Norman, Gordon and PePOSE, 1984; Lewinsohn, Seeley, Moerk and Streigel-Moore, 2002; Strober, Freeman, Lampert, Diamond and Kaye, 2001). Little is known about men with eating disorders and published research is sparse (Keel, Klump, Leon and Fulkerson, 1998), possibly because of the relative rarity of these problems in males (Carlos, Camargo and Herzog, 1997; Fichter, Daser and Postpischil, 1985). Eating disorders in men are becoming increasingly recognised as a problem and risk factors for the development of body image disturbance is an active area of research. The rarity of eating disorders in males raises questions about the aetiology of these disorders (Hall et al, 1985). What is it that causes eating disorders to develop in some men?

There have been suggestions that males with eating disorders do not differ greatly from their female counterparts (Ellis and Cantrell, 1985; Hall et al, 1985; Keel et al, 1998; Olivardi, Pope, Mangweth and Hudson, 1995). In spite of this, one notable difference between male and female eating disordered patients is sexual orientation. Sexuality appears to have a role in eating disorders for both males and females and has been investigated because a disproportionately high number of homosexual males have been identified within male patients presenting to eating disorder services. This literature review aims to identify the broad relationships between eating disorders and sexual/gender identity.

Homosexuality

The question of what does and does not constitute homosexuality has caused considerable debate in the past. The term 'homosexual' derives from the Greek root 'homo', emphasising the sameness of two individuals involved in a sexual relationship (Kinsey, Pomeroy and Martin, 1972), suggesting a focus on a person's behaviour. Hoffman (1968) states that homosexuality describes any individual sexually attracted to partners of the same sex, but not necessarily sexually active. The distinction between behaviour/ lifestyle and sexual orientation is also discussed by Gonsiorek and Weinrich (1991) and continues to cause debate. Homosexuality is a social construction in that its definition and importance is determined by the culture in which it is examined (Weeks, 1999). In modern Western society it is generally accepted that homosexuality is not a conscious preference (Gonsiorek and

Weinrich, 1991) and that an individual is homosexual if they are predominantly sexually attracted to people of the same sex. Engagement in sexual activity is not essential for a person to consider himself or herself homosexual. For research purposes, individuals are generally asked to indicate whether they consider themselves to be homosexually or heterosexually orientated, although specific measures such as numbers of homosexual experiences are sometimes used. The difficulty in categorising people by sexual orientation is discussed later in the chapter.

Sexual activity

It has been suggested that males with eating disorders display heightened anxiety relating to sexual activity and relationships compared to females (Fichter et al, 1985; Herzog, Bradburn and Newman, 1990). Anorectic men are also reportedly less likely to have experienced pre-morbid sexual relationships than anorectic females (Herzog et al, 1990) and this has been found to impact on prognosis. Hall et al (1985) compared 27 male and female anorectic patients and found “lack of normal adolescent sexual behaviour” (p323) was strongly predictive of poor outcome, whilst active sexual fantasy and masturbation were strong predictors of good outcome.

Could the differences in treatment outcome be related to the causes of eating disorders, for example an attempt within males to repress sexual desire? One explanation for the occurrence of eating disorders in males is that males with eating

disorders are more feminine than other men. A small positive relationship between femininity and eating disorders and a small negative relationship between masculinity and eating problems may exist (Fichter and Daser, 1987; Murnen and Smolak, 1997). It is possible that more feminine men feel less able to attract women in a society dominated by images of masculine men, resulting in eating disorder pathology. Men who are uncertain or uncomfortable about their sexual identity may also develop eating disorders to cope with these difficulties, although increased femininity has not been found within this population (Russell and Keel, 2002).

Sexual conflict

Men with eating disorders exhibit issues about gender identity or sexual conflict (Anderson, 1990), gender dysphoria and/or homosexual orientation more often than females and conflict over sexual orientation may precipitate the development of an eating disorder in many males (Herzog et al, 1990). Homosexuality has been suggested as a predisposing factor to eating disorders in males as homosexual males have a higher incidence of eating disorders and body image disturbance than heterosexual men (Anderson, 1990; Boroughs and Thompson, 2001) and are over-represented in eating disorder services (Fassino et al, 2001; Herzog et al, 1990; Silberstein, Mishkind, Striegel-Moore, Timko and Rodin, 1989). A small number of studies have found no relationship between homosexuality and eating disorders in males. No homosexuality was found in a study of nine anorectic males (Hall et al, 1985) and in another study, homosexuality was no more prevalent than would have

been expected in the general population (Olivardi et al, 1995), however there is a substantial amount of evidence to suggest that a link does exist.

Homosexuality and eating disorders

A number of studies have been conducted to investigate the relationship between homosexuality and the development of eating disorders in men. Several studies have reported significantly higher than expected levels of homosexuality amongst male eating disordered patients (French, Story, Ramafedi, Resnick and Blum, 1996; Heffernan, 1994; Herzog et al, 1990) with levels as high as 30% (Herzog, Newman and Warshaw, 1991). Young homosexual males aged 12-20 were also found to have higher rates of body dissatisfaction and eating problems than their heterosexual peers (French et al, 1996).

Herzog et al (1990) state that many anorectic males seem to view their homosexual orientation disfavouredly and comment that Crisp (1970) suggested that fear or guilt resulting from a homoerotic experience may precipitate an eating disorder, with the aim of decreasing libido. Burns and Crisp (1984) identified a patient who was relieved by lower sex-drive resulting from his anorexia because of concerns over his possible homosexuality. Although it seems unlikely that men would intentionally starve themselves to decrease their libido, it is possible that concerns about sexuality could maintain an eating disorder.

Only two studies directly examining the link between homosexuality and eating disorders were found. Herzog et al (1984) compared anorectic and bulimic males and females. Statistically significant differences were found between males and females in terms of sexual behaviour, with males significantly more likely to be asexual or homosexual. 26% of the male sample was homosexual, compared to 4% of the female sample and five out of seven of the males stated during interviewing that they experienced conflicting emotions regarding their sexuality. The sample size within this study was small but results suggested sexual isolation, inactivity and conflicted homosexuality in male eating disordered patients.

Carlos et al (1997) studied 135 male patients with eating disorders from across all clinical units of Massachusetts General Hospital and ascertained sexual orientation from 122 of these. They found that 41% of the patients were heterosexual, 27% were homosexual or bisexual and 32% were asexual. Of the asexual patients, 22 expressed a specific sexual orientation; 27% were homosexual. Homosexuality and bisexuality were more prevalent in bulimic patients whereas asexuality was common within anorexia nervosa and "Eating Disorder Not Otherwise Specified" diagnoses. Many patients reported that their sexuality played a part in the development of their eating disorder and five of the homosexual men explicitly stated that their eating disorder began in response to pressures towards thinness in their subculture (Carlos et al, 1997), a suggestion that had also been made by Herzog et al (1984).

Body image ideals

Studies have also been carried out with non-clinical samples to investigate the relationship between homosexuality, body image and eating disordered behaviour. Homosexual men who do not have eating disorders have been found to experience higher levels of body dissatisfaction, bulimic and anorexic symptoms than heterosexual men (Boroughs and Thompson, 2001; French et al, 1996; Herzog, et al, 1991; Russell and Keel, 2002; Silberstein et al, 1989). Homosexual males also have thinner body ideals, are themselves thinner and are more likely to want to be underweight (Herzog et al, 1990; Herzog et al, 1991). Despite being thinner than heterosexual males and perceiving their bodies as similar to their ideal, homosexual men are less satisfied with their appearance and may fear weight gain because this would make them heavier than prospective partners would find attractive (Herzog et al, 1991).

Men rate physical attractiveness and slenderness as more important in potential partners than women (Brand et al, 1992; cited in French et al, 1996). Homosexual men and heterosexual women may be more likely to experience body dissatisfaction and be vulnerable to eating disorders because of a shared emphasis on physical attraction and thinness, based on the desire to attract and please men (Seiver, 1994). Seiver (1994) found that there were significant differences between heterosexual and homosexual men and women and stated that the differences could be explained by the degree of sexual objectification experienced. Homosexual men

and heterosexual women showed high concern for physical attractiveness and thought that physical appearance was important to their male partners, whereas heterosexual men and homosexual women were less concerned. Homosexual males believe that their partners prefer thinner bodies than heterosexual males (Boroughs and Thompson, 2001), which may result in increased efforts to conform to this size.

Homosexual culture

One explanation given for increased body dissatisfaction and eating disordered behaviour in homosexual males has been the increased importance of physical appearance within male homosexual culture. Homosexual male culture places elevated importance on all aspects of physical presentation and appearance is considered central to the homosexual male's sense of self (Epel, Spanakos, Kasl-Godley and Brownell, 1996; French et al, 1996; Herzog et al, 1990; Silberstein et al, 1989) resulting in pressure to remain thin and attractive (Heffernan, 1994; Seiver, 1994). This pressure does not exist within female homosexual culture and may act as a protective factor against eating disorders for homosexual females (Seiver, 1994). The link between affiliation with the homosexual community and body dissatisfaction has been studied and affiliation with the male homosexual community was a significant predictor of body dissatisfaction, possibly through increased pressure to diet (Beren, Hayden, Wilfley and Grilo, 1996).

Pressure to remain thin and attractive appears to be a factor that increases body dissatisfaction for people within subcultures where this view is prevalent. This mainly affects heterosexual females and homosexual males, which may explain the increased occurrence of eating disorders within these groups. There is support for the idea that homosexuality may lead to the increased incidence of eating disorders in males because of the pressure on homosexual males to be thin and fit in with this subculture (Herzog et al, 1990; French et al, 1996; Seiver, 1994; Silberstein et al, 1989). This view is not supported by all studies, however, as body dissatisfaction has been found in homosexual males as young as 12, leading French et al (1996) to conclude that a 'gender nonconformity explanation' may be more feasible than sociocultural emphasis on physical appearance because youngsters are unlikely to have become immersed in the subculture or its associated pressures.

Discussion

There appears to be a link between eating disorders and homosexuality in males. Male homosexuals are over-represented in eating disorder services when compared to the percentage of male homosexuals in the community. It is possible that homosexuals are over-represented in eating disorder services for other reasons, however, as homosexual males may be over-represented in most psychiatric populations (Herzog et al, 1990) and may be more prone to mental health problems because of their treatment and status within society. Homosexuality may also

aggravate and make the course of eating disorders more severe in male sufferers, rather than being instrumental in their development, leading to more homosexual than heterosexual males presenting to eating disorder services (Carlos et al, 1997).

It is possible that homosexual men are over-represented within eating disorder services because heterosexual men are under-represented through reluctance to seek help (Heffernan, 1994; Herzog et al, 1990). Societal expectations about the ability of men to cope with psychological distress and the view that eating disorders are primarily a female problem may discourage men from actively seeking support. Heffernan (1994) also comments that when self-report measures are used within studies, heterosexual males may have a tendency to under-report problems through reluctance to admit dysfunctional attitudes or behaviours, which could similarly have biased results.

Despite these concerns, research using non-clinical samples also suggests that homosexual males are more concerned about appearance, more dissatisfied with their bodies and are more likely to display attitudes and behaviours linked to eating disorder pathology than heterosexual men. It is possible that this is caused by pressure to conform to the standard of attractiveness set within the male homosexual subculture or may be related to homosexual men perceiving themselves as objects of sexual desire and wishing to attract other men (Seiver, 1994). The social influences in the development of eating disorders in homosexual

men clearly needs further research so that the relationship can be better understood.

Research Limitations

This literature review is clearly limited by the amount of literature available regarding homosexual males and eating disorders. Clearly there are problems with researching this population due to homosexual males already being a minority group and potential participants being further limited to a subgroup of these males who develop eating disorders. The small sample sizes within some of the studies seemed to reflect this difficulty and the quality of the papers found relating to males and eating disorders varied greatly. Case studies were commonplace amongst the literature regarding males with eating disorders, although the body of research is growing.

There were further limitations within the literature as it currently stands. Many of the scales used to assess eating disordered behaviour and attitudes within the research were designed and developed for use on female populations (Seiver, 1994). It may therefore be that these scales do not accurately assess eating disordered symptomatology or attitudes within male populations. It is necessary for research to be carried out so that the suitability for currently used scales can be assessed or for separate scales to be developed for use with both heterosexual and homosexual men.

There may also be differences between results found in different studies because of the way in which homosexuality is defined. Heffernan (1994) states that there is a difference between stable homosexual orientation and adolescent experimentation with homosexual experiences. Self-report regarding homosexuality may lead to people who are uncomfortable with their sexuality not disclosing that they are homosexual either during research questioning or indeed within therapy. Similarly research measuring sexuality by sexual experience, as opposed to sexual attraction towards different groups, may also alter results. If anorectic males are less likely to have had any premorbid sexual experience, measuring sexual activity will prejudice their orientation scores, particularly as anorexia reduces libido, so chronic anorectics may not have had a sexual relationship for a number of years. Individuals may also be limited in their number of sexual contacts, possibly through not finding appropriate partners or through having been in a long term, stable relationship with one individual.

Further research

A number of avenues for future research within this area exist. The factors that increase risk for eating disorder development within homosexual males are currently unclear (Heffernan, 1994) and further investigation into specific factors such as body-dissatisfaction, gender identity conflicts, the increased value put onto appearance and affiliation with the male homosexual community need further

investigation. It is also possible that currently unknown variables are important in eating disorder development within this group of men. Further research to obtain a clearer and more consistent picture of differences between homosexual and heterosexual men and women is also an important area of further investigation (Seiver, 1994). More research is necessary to identify subgroups of males in which eating disorders appear to occur more frequently so as to enable earlier diagnosis and so that preventative measures can be developed (Anderson, 1990). Treatment may then also be tailored more specifically to these clients.

An interesting point was made by Heffernan (1994) in that many of the studies on homosexuality and eating disorders were carried out in the 1980s when AIDS was becoming increasingly prevalent and more publicised. The widespread publicising of AIDS may have resulted in changes in physical ideals, as the equation of thinness with illness might be reducing its allure within the homosexual community, which may impact on prevalence of eating disorders in homosexual men (Heffernan, 1994). Ten years on, it does not appear that the advent of AIDS has impacted on the thin ideal within society, although it would be interesting to see whether the increasing numbers of males presenting to eating disorder services are homosexually or heterosexually orientated, as it may be that heterosexual men have become more prominent within services.

Conclusion

The exact relationship and impact of homosexuality on eating disorders remains unclear, although it seems likely that external pressure from the homosexual subculture and the impact on self-esteem of being part of a minority group may increase susceptibility to the disorder. "If social stigmatisation of homosexuality caused general psychological distress that expressed itself as discomfort with sexual orientation, poor self-esteem, depression and disordered eating, homosexuality might act as a general risk factor" (Russell and Keel, 2002, p301).

Clinical implications

When working with any client group it is important for a clinician to be aware of the factors involved in the development and maintenance of the difficulty and for a thorough formulation of the difficulties to take place. An individual's sexuality and potential pressure from their culture may be amongst the environmental factors considered by a clinician formulating an individual case, however for homosexual males presenting to services, this may be particularly important. Individuals presenting to services may feel uncomfortable in talking about their sexuality, may see this aspect of their life as irrelevant to their current difficulties or, if comfortable with their sexuality, may resent any suggestion that their subculture is somehow to blame. Sensitivity is therefore essential and it is important to ascertain how much of an issue societal pressure is for an individual.

Within therapy, it is important for a clinician to be aware that if a male is strongly affiliated and involved with the homosexual culture and part of that is to be slim and attractive, it may be that the individual finds it more difficult to engage in therapy and make changes to their eating behaviour because of the impact that this may have on their acceptance within their culture. Challenging beliefs related to image, its importance and role within the individual's culture may have heightened importance and be more difficult to shift with these clients.

Heffernan (1994) comments that existing treatments for eating disorders such as Cognitive Behavioural Therapy should not need to be dramatically altered for homosexual patients, however emphasises that therapists working with homosexual clients need to be familiar with issues relating to sexual orientation and gender identity. Clinicians working with eating disordered males and females need to be aware of the particular experiences and issues relating to homosexual males and females so as to be able to best meet their healthcare needs (Heffernan, 1994).

It is likely that within eating disorder services individual clinician's knowledge relating to sexual and cultural differences vary enormously and it may therefore be beneficial for services to provide training for clinicians working with individuals for whom sexuality might be an issue. Clinicians may benefit from access to appropriate literature and possibly also specialist services that are more knowledgeable about issues affecting homosexual individuals. Similarly, it is essential for supervisors to

be aware of these issues so as to ensure that important factors are not overlooked and so as to be able to guide more junior clinicians or colleagues to relevant resources for cases in which sexual orientation seems to be an important issue.

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Chapter Two

The Role of Media in the Development and Maintenance of Eating Disorders: A Grounded Theory Approach

Abstract

Objective: This study was designed using techniques from grounded theory methodology to explore experiences of people diagnosed with anorexia and bulimia nervosa, specifically with regards to the relationship that culture and media played within their eating disorders. Previous research suggests a link between media, body-image dissatisfaction and eating disordered behaviour. Qualitative research using eating disordered participants may provide greater understanding of this relationship.

Method: Nine adult female participants with anorexia and bulimia nervosa participated in semi-structured interviews to explore eating disorder development, media use and the role of media within the development and maintenance of their difficulties. Transcriptions were analysed using techniques based on grounded theory so as to create a model incorporating these experiences.

Results: Media appear to play an indirect role in eating disorder development through external pressure and reinforcement of societal values. Media also

contribute to the maintenance of disordered thinking, particularly with regards to ambiguity around improvement and change and create disparity between the desires of individuals and societal values.

Conclusions: These findings contribute to previous research suggesting a link between media and eating disorders because experiences of people with anorexia and bulimia are incorporated into the research on media's influence on their difficulties. Media appear to play a role in eating disorder development and maintenance, although this is not a straightforward causal relationship. Implications for treatment are discussed.

For several decades now, the prevailing view in Western society is that the mass media are instrumental in the development and maintenance of eating disorders, particularly in young women. The exact nature of this influence is, however, still open to question. Most research in the fields of communication and psychology has investigated the issue through multivariate analyses of media consumption and cognitive measures of body dissatisfaction (e.g. Botta, 2000; Champion and Furnham, 1999). Such analyses tend to gloss over the complex relationship between individuals and media. The aim of this study was therefore to conduct in-depth interviews with a number of women with anorexia and bulimia nervosa. It was hoped that these would elicit sufficient information about the interviewees' relationship with media to examine the precise processes by which media exert their influence on eating behaviours and cognitions.

Within Western society a thin body is considered attractive, and being attractive is valued as important and a sign of success (Palmer, 2000; Seiver, 1994). People are trying to keep a youthful, slender appearance for longer, some paying incredible amounts of money for surgery to make them look slimmer and 'more beautiful'. Many people diet for aesthetic rather than for health reasons (Schwartz, Thompson and Johnson, 1982) and the physical ideals that people set for themselves can be unrealistically thin and dramatically below normal weight standards (Groesz, Levine and Murnen, 2002; Myers and Biocca, 1992) making them difficult, if not dangerous, to achieve.

Awareness of body image develops during childhood and body image dissatisfaction can also develop at a young age (Shapiro, Newcomb and Loeb, 1997; Truby and Paxton, 2000). Media appear to play a role in body image development and there is substantial research evidence to support the link between body image disturbance and the media (e.g. Botta, 1999; Botta, 2000; Harrison, 1997; Harrison and Cantor, 1997; Myers and Biocca, 1992). Images portrayed within the media construct an ideal towards which people aspire (Groesz et al, 2002; Livingstone, 1998) and media messages promote the idea that slim women are more attractive, higher achieving and more successful (Gowers and Shore, 2001; Myers and Biocca, 1992) increasing many women's desire to be thin. Internalising thin ideals can lead to decreased self-esteem and eating-disordered behaviour (Groesz et al, 2002).

Most people experience similar levels of media exposure, as media are an integral part of modern life (Livingstone, 1998), however some women appear to be more vulnerable to messages that thinness is important. A history of body-image problems and eating disorders appear to increase women's susceptibility to media images, body dissatisfaction and size overestimation (Groesz et al, 2002; Hamilton and Waller, 1993). "Media promotes, if not establishes, a standard of slender beauty that leads many women to feel badly about their weight and shape" (Groesz et al, 2002, p12). Media may also be related to changes in eating behaviour. The media promoting a thin body ideal and women feeling dissatisfied with their weight

and shape may motivate some individuals to diet and lose weight (Slade, 1982), which may result in obsessive and unhealthy eating behaviours in some women (Myers and Biocca, 1992).

Although there is a substantial amount of quantitative research investigating the impact of media on body image, little is known about the subjective experience of people with eating disorders regarding their relationship with the media. Previous research has mainly focused on individual aspects of experience, such as mood or body-size estimation following the presentation of thin media images (Hamilton and Waller, 1993). Qualitative approaches further the understanding of data obtained through quantitative methods, whilst also potentially producing novel material through the exploration of individuals' subjective experience (Foster and Parker, 1997).

As stated above, research evidence suggests that media influence people. Media subtly alter peoples' ideas, social roles and personal activities by portraying a message that, although based on the standards of the society, ensures people continue to aspire to certain ideals, for example people considering themselves 'consumers' rather than 'citizens' (Lull, 1995).

When asked, people generally state that they are not affected by media messages. There is a well-documented phenomenon within the communication literature known

as the 'third person effect', where individuals regularly overestimate the influence of media on others in comparison with that on the self (Perloff, 1999). As individuals are generally unaware of the impact that media have on them, it is important to understand what influence they do have. This research aims to further understanding of eating disorders and the factors important in their development by addressing this area, with the view to further enhancing therapeutic techniques currently used with these clients.

There are numerous qualitative approaches to research, however within this study techniques from the grounded theory approach (Glaser and Strauss, 1967) were chosen because the researcher wished to develop the understanding of these issues further than describing themes and to develop a theory encompassing the key issues identified within the data.

Method

This study uses techniques developed within the grounded theory approach (Glaser and Strauss, 1967), and described by Strauss and Corbin (1998). These techniques were chosen so as to employ a structured and focused methodology to analyse the participants' experiences but without constraining or influencing their responses. The interviews were semi-structured and designed to elicit media related content, rather than being inclusive and covering all areas of eating disorder experience as

would have been employed within a true grounded theory approach, due to the specifically media related research question.

The researcher did not want to simply describe themes and trends within data but to develop a theory based on the information provided by participants to explain the relationship between media and eating disorders. “Rather than using data to test hypotheses derived from previous literature of a topic – as in most quantitative research – (grounded theory) generates theory from the data themselves” (Giles, 2002, p166).

The branch of grounded theory chosen for use within this research was the constructivist approach, as described by Charmaz (2000). The constructivist approach emphasises the participant’s subjective experience of the phenomena under investigation rather than an empirical ‘truth’ awaiting discovery, as assumed by the reductionist approach. Charmaz (1995, 2000) and Giles (2002) describe these more recent developments within grounded theory methodology.

Ethical Considerations

Ethical approval for this study was obtained from Coventry University and from Warwickshire Local Research Ethics Committee (LREC) (See appendix E and appendix F respectively). Participants met with the researcher to become acquainted before the interviews took place, and so that any questions could be

answered, ensuring informed consent was obtained. Interviews were carried out either in the participants' homes or in a room at the eating disorder service, determined by the participant's preference. It was stressed to participants that they could withdraw their participation at any stage of the research process. A debriefing took place after interviewing.

Participants

The inclusion criterion for this study was a diagnosis of either anorexia or bulimia nervosa, as diagnosed by the Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association, 1994). Participants were recruited from an eating disorder service within the West Midlands and were required to be receiving ongoing support from that service so that, in the unlikely event that any distress arose following participation, this could be addressed immediately with the participant's therapist. Participants were restricted to females over 18 years of age in order to comply with Warwickshire LREC requirements (n=9, mean age = 30.8, range 19-53). Participants who were currently being treated as inpatients within the unit were also excluded due to their fragility during that stage of treatment. For reasons of confidentiality, participants within this study are referred to by randomly assigned names, alphabetically allocated based on their position within the interviewing process. All other potentially identifying information was also removed from transcripts so as to protect identities.

Procedure

(For a detailed analytic procedure, see appendices G, H, I and J).

Data was collected using semi-structured interviews and data collection and analysis occurred simultaneously. Seven interviews were conducted during the open sampling and relational sampling phases of data collection, where open coding and focused coding were carried out. At this point saturation was reached and all new information examined fitted into the previously defined categories. Axial coding and the final analysis were then carried out so as to identify relationships between the codes and develop a theory encompassing the data. A further two interviews were conducted so that theoretical sampling (Charmaz, 2003) could be undertaken to address issues of reliability and validity and to ensure that the new data obtained fitted the theory developed. Detailed memos were kept to document the research process and to ensure that the theory was grounded in the data (Giles, 2002). (Examples of reflective and analytic memos can be seen in appendix K).

Analysis

36 lower order categories were identified during the initial coding phase (see appendix M for a list of lower order categories). These were refined into 8 higher order categories during axial coding: Control, Loss, Health, Escapism, Competitiveness, Visibility, External Pressure and Fascination with Food.

Final analysis identified a core category that underpinned the other higher-order categories, which was termed 'Conflict'. The relationship between the higher-order categories is illustrated in the model depicted in Figure 1.

Each of the higher order categories will be discussed in turn, finishing with the core category.

CONTROL

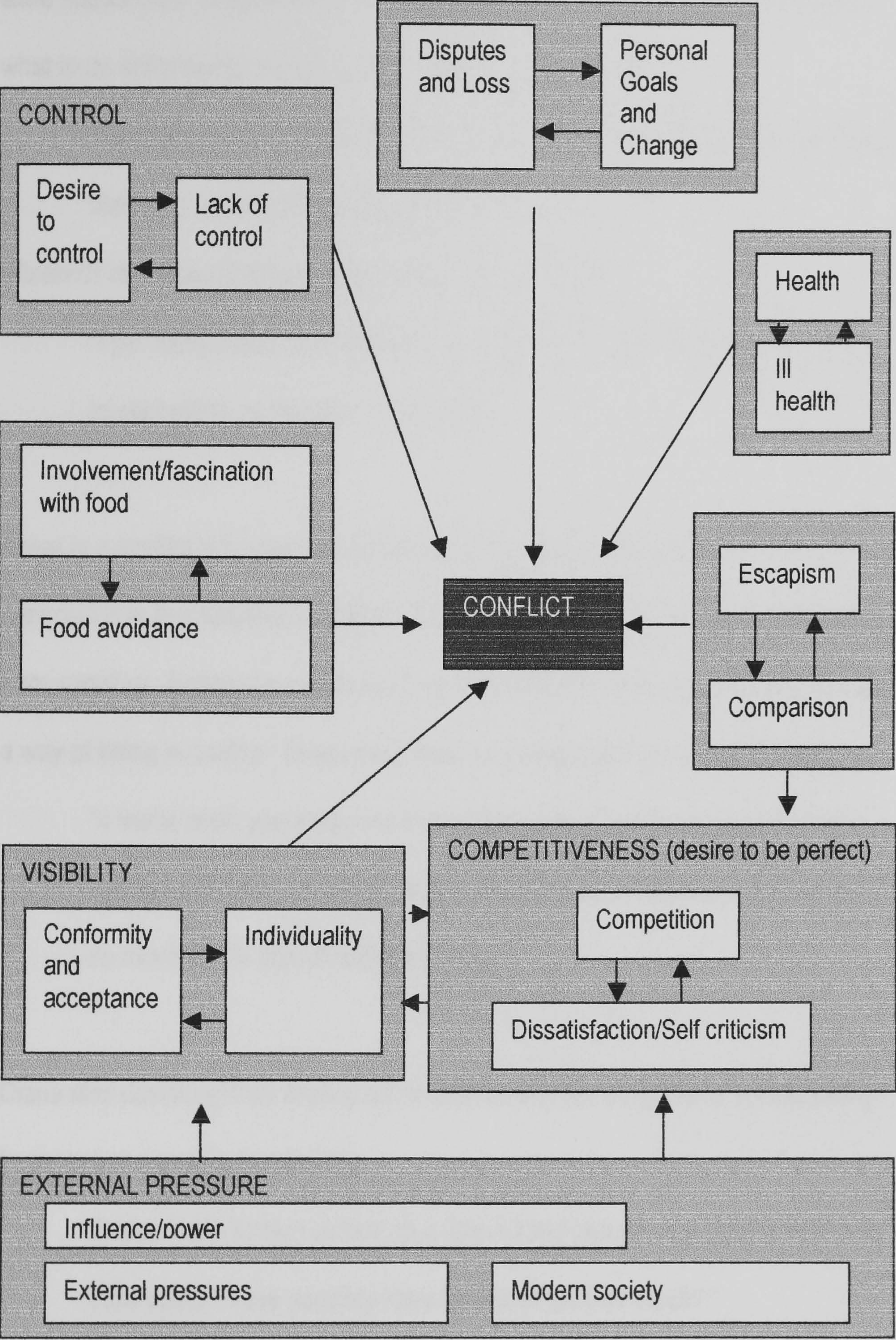
Joseph (1982) states that media and cultural messages promote an image of being in control. Participants described a struggle between the media's constant advertising of calorific foods but simultaneously the message that people should eat healthily and be thin. This led to conflict within participants about the need to be in control and restrict their eating, or to give in to temptation and risk being out of control. Gemma described the conflict between watching adverts for high calorie foods on the television and wanting to eat them.

"I do look at it (...) just by looking at the food I feel guilty, the temptation for chocolate..."

Through not being tempted by the advertising, Gemma felt as though she stayed in control.

Control was contradictory because participants expressed a desire to be in control, which led to the development of the eating disorder, contrasting with the lack of

Figure 1: Diagrammatic representation of model relating media and eating disorders



control within participants' lives because of the eating disorder and the associated extra support and supervision deemed necessary. Elizabeth described being told what to do whilst being treated as an inpatient.

"Having to sort of like sit for an hour after every meal and snacks and sort of like very 'Do as you're told' type of thing".

Elizabeth also described feeling unable to get better alone

"I get really down now because I don't feel like it's my choice (whether or not to get better), or maybe I'm just weak".

There is a conflict because having an eating disorder is also considered to be out of control due to the person's inability to make themselves eat or to stop themselves from vomiting. Eating is considered to be out of control, making the eating disorder a way of being in control. Diana described how anorexia takes control saying

"It feeds itself, you know, the more that you go round in that circle of not eating much and not wanting to eat much the more it, you know, you get... so much of it is sort of self-reinforcing"

Diana also described how feeling out of control with her weight was a contributing factor to her anorexia developing.

"It was really funny I picked up a size 18 and picked up a size 10 and went 'How could I have possibly have let myself go that much?'"

Diana also commented

“I’m either eating for England or eating for Ethiopia”.

Controlling the amount that we eat is desirable within our society and even 8-10 year olds are familiar with the cultural view that thinness and restrained eating are desirable (Shapiro et al, 1997). Media messages increase the person with the eating disorder’s desire for control, but simultaneously enhance their lack of control through the eating disordered behaviour.

HEALTH

Health was another category that participants suggested was influenced by the media and was a source of conflict for them. Many of the participants spoke of reading health-related magazine articles and expressed a desire to be healthy. The media increased their conflict by suggesting that a thin body signifies health and focusing on the idea that the nation is becoming increasingly obese. Florence expressed that she had always been health conscious, saying

“I didn’t think about what I ate, other than I wanted it to be healthy”

but stated that media messages about what is good and bad to eat had confused her.

“The worst thing about the Atkins’ diet at the moment, it’s quite scary actually that my antenna picks it all up, so I just end up getting confused and

finding it more and more difficult to know what to eat, I could give it up totally”.

Florence also described confusion because she had read an article about fruit.

“I read in a magazine an apple contains 6 teaspoons of sugar and it was almost like as soon as I read it, I really wished I hadn’t, really, really got in my head that I really shouldn’t be eating it, don’t even know if it’s true”.

As participants identified, media and cultural messages promote a positive stereotype of beauty, success and health (Garner and Garfinkel, 1980; Kaufman, 1980). There is also a negative stereotype portrayed of poor health and lack of control for people with obesity (Ritenbaugh, 1982), which enhances the stereotyped image of a thin ideal body (Myers and Biocca, 1992). Women with eating disorders seem to focus on the message that people need to lose weight and apply this to themselves, despite the knowledge that losing weight actually makes them become unwell. Gemma stated,

“Part of me wants to be healthy and to lose weight, and when I lose weight, I get very ill and have to go into hospital”.

Gemma continued

“Yeah, healthy is losing weight, definitely, because like on the news and that they’re saying everyone should lose weight”.

The conflict between 'thin = healthy' - the desire to lose weight, and becoming ill and putting their lives at risk through continued weight loss appeared to be made worse by media messages about food and eating.

FASCINATION WITH FOOD

Related to the media's message about health and diet was a fascination with food described by many of the participants. Florence described having an "antenna" that unconsciously picked up information about food from sources around her. Diana described food magazines as like

"Anorexic porn, and you know that is so, so true and it's like I'll do everything to do with food except for actually eat it".

Gemma stated

"A part of me does not want anything to do with it and a part of me thinks about it all of the time".

The media are constantly giving out conflicting messages about food. Kaufman's (1980) study argued that the media delivered conflicting messages as characters were portrayed eating in unhealthy ways, yet the message delivered was that people should strive for thinness. "Not only are viewers presented with an unrealistically thin body image, they are often presented with one that remains thin despite frequent snacking and unbalanced meals" (Myers and Biocca, 1992, p111). Many of the participants were ambivalent about eating, constantly thinking about and wanting

food, whilst desperate not to eat, creating a battle between the need to survive and the need to be thin.

VISIBILITY

The conflict and struggle within this category related to participants' desires to conform to the media portrayed ideal of beautiful and popular, compared to their desire to be individual and different. Alice reported

“To a degree I’m still sort of trying to pull myself back and get all of that individualism back, but I think that there’s such a thing to conform”.

Anderson (1990) described participants expressing a fear of ‘nothingness’, a lack of identity without their eating disorder. A conflict exists because the eating disorder enables the individual to conform and fit in with others by becoming thin, whilst also giving them an identity and making them different.

Many of the participants interviewed during the research described wanting to be ‘perfect’ and that weight loss was part of trying to attain that goal. Garner, Garfinkel, Schwartz and Thompson (1980) comment on the media ideal of incredibly thin females, stating, “It is ironic that the current symbols of ‘sexual attractiveness’ may be gravitating towards a weight which is in biological opposition to normal reproductive activity” (p490), infertility being in opposition to the ‘perfect woman’ ideal. For other participants the battle concerning visibility was whether or not they wanted to be seen at all, trying to be more than just symptoms of the disorder (i.e.

an individual) but also wanting to disappear rather than to develop a sexual body.

Crisp (1997) describes anorectics trying to reverse the pubertal process and avoid being visible to men. The media promote an ideal for women to aspire to which involves being desirable and popular, as well as successful. Individuals therefore experience a conflict between whether they wish to conform and fit in, or be unique.

Participants described their self- image and the perceptions that they believed other people had of them. Many of the women talked about how visible they thought they were to other people. Alice described how she used to enjoy being noticed.

“And if you’d’ve seen me when I was at college I was very kind of different and I quite enjoyed standing out from the crowd (Laughs)... I had 7-inch platform boots, shocking pink hair, 48 inch flares”.

Claire described wanting to make herself more noticeable to her husband.

“I always thought that she (her husband’s ex-partner) looked slimmer and prettier and if I was slimmer he’d love me”.

Diana furthered this, linking her desire to be thin with the media’s image of beautiful.

“You do tend to start thinking ‘Well, you know, how can Jeff love me because I don’t look like her?’”

Other participants used weight loss as a tool to increase their self-esteem as people commented on their size (Anderson, 1990).

Belinda stated

“Although it’s a silly thing really, people would say ‘Gosh you’ve lost weight, you look so thin’, and instead of me thinking ‘Oh, time for me to, you know, draw back’ that would really push me on”.

Belinda described continuing to diet because she was concerned about losing the positive comments from others. There is a strong message that thinness is desirable within society and that to be successful and loved a woman should be thin, a message that the media reinforce.

COMPARISON, COMPETITIVENESS and EXTERNAL PRESSURE

Strongly related to visibility is the tendency for comparison and competition within eating disordered women. Many of the participants described being self-critical, negatively comparing themselves with others and the desire for self-improvement.

For some participants, comparison was directly linked to the media. Claire commented

“Admittedly I’ve looked through magazines before and thought ‘Oh gosh, she looks really nice’, you know ‘Ooh, I wish I had legs like that’”.

Gemma reported

“I think probably I’ve always compared with other people, everywhere, on television, in films and just people who I see”.

Elizabeth said

“I always do that now, like when you walk down the street or (...), whoever you meet I’m always like “Are they thinner than me?” you know, that type of thing”.

For other participants, non-media external pressures such as other people’s comments and influence over them were more prominent. Although the thin ideal is reinforced by multiple factors within society, the most aggressive message that thinness is beautiful and desirable comes from the media (Groesz et al, 2002).

Some of the participants compared themselves with exceptionally thin and attractive celebrities. Diana said

“I am very self-critical and you do tend to compare yourself to them (celebrities) and it’s that sort of, well I... I don’t know but you end up sort of doing things like ‘Well, I’m not as thin as Victoria (Beckham) but I’m not as fat as Kerry McFadden’ (laugh), you’re aspiring to, you know, to be towards Victoria”.

It has been suggested that the way in which a person processes media images is important and that comparison is unhelpful (Botta, 1999, 2000; Groesz et al, 2002; Martin and Gentry, 1997). When people compare their own attractiveness to slender models, this causes more difficulties than when people look at slender models in an inspiring way (Martin and Gentry, 1997).

LOSS and GOALS

Loss and goals is not as strongly related to the media as the other categories, although goals of weight loss could have been more related to media influence than the participants reported (the 'third person effect', Perloff, 1999). Most lay-knowledge about eating disorders also stems from media sources, which leads to the media indirectly informing peoples' perceptions and beliefs about eating disorders, and therefore their reactions to others with eating disorders.

This category incorporated difficulties expressed by participants, such as feeling isolated and disliking the deception that the eating disorder had led them to develop, but the conflict that this had with their desire to remain thin. The media are also likely to have fuelled guilt related to deception because of their reinforcement of this moral value. For one participant there was a conflict between their desire to get better but their friend's resistance, wanting them to remain in the ill role. Conflict and disharmony between what the individual with the eating disorder wanted and their loved ones seemed to play a prominent role in their eating disorder.

Core category: CONFLICT

Initially this core concept appeared to be 'Ambivalence', a term which is regularly used to describe anorectic patient's attitude towards recovery (Palmer, 1988), however on re-examining the data, it became apparent that the descriptions and experiences described by participants were less about being undecided and more

being in a battle with themselves. Inconsistency and divergence within the categories left the participants in a state of conflict.

Diana stated

“It’s just that horrible sense of being at war with yourself all the time, it’s very exhausting”.

This seemed to encapsulate the experience of all of the participants.

Conflict appears to be central in linking the role of media to women with eating disorders. Conflict is known to play a large part within eating disorders and sufferers often feel locked in a battle (Palmer, 1988). The idea that media are part of this conflict has not previously been applied to eating disorders, but clearly links the issues described by participants to the media. Media and cultural messages about women’s roles and success are influential and motivate many women to achieve, however the drive for success and perfectionism within females with eating disorders appears to intensify this desire. Thinness and attractiveness are synonymous to success within the media, as is the need for self-control. The conflicting messages about food, desirability, control, individualism and conformity make overcoming an eating disorder more difficult because the hegemony of the media has to be overcome.

Discussion

Eating disorders appear to develop in the context of difficult early life events such as abuse or separation from caregivers (Palmer, 1988). When these predisposing factors are combined with the dominant social script that thinness is desirable and the media's message that attractiveness and success are interrelated, it seems somewhat inevitable that for some people this will become pathological and result in disordered eating. People with eating disorders appear to be more susceptible to media messages about thinness and these reinforce the ideas they already have about the importance of becoming and remaining thin. Media offer thinness as a (relatively) easy means of success, and as something that will enhance a person's quality of life and make other difficulties more manageable.

As can be seen from the analysis and results, media seem to play a role not only in the development of eating disorders, through promoting an image of thin and attractive women, but also in their maintenance by the repeated message that people in Britain are becoming increasingly obese and need to lose weight. Women are unable to resolve these conflicts without giving up on one of their strongly held desires or beliefs, and are therefore unwilling to change, living with the disorder until a cognitive shift occurs. This is likely to be the reason for the ambivalence often described by therapists in treating anorectic and bulimic patients.

The participants within this study stated that comparison was important within their lives, a phenomenon born from a competitive and capitalist society where focus is on personal ability and success. The participants primarily compared to the people around them, which is presumably likely to have a similarly negative impact as comparing to media figures, although the models for comparison may be less 'perfect'. Media appear to increase the individual's desire to compete and provide a wider range of people to compare to than would have been available prior to the advent of television.

Media create pressure to conform and media images seem to be used by people as a template for how they should live their life or how they should be. In the past the Church was the leading source for guiding people with regards to what they should do, however this was more morally based and pertaining to souls. The media now appear to have acquired this role and not only suggest morally and politically sound judgement, but set other ideals such as standards of beauty and desirability. Most media, including television, magazines, the internet and billboards, are visual. This enhances the importance of the physical ideal because the majority of people seen within the media are aesthetically attractive, which may lead to the belief that 'the average person' is this attractive. Larger role models within media are generally either comedians or are portrayed in a somewhat frumpy and less glamorous light. There is also often the underlying message that larger people wish to lose weight, making their size more acceptable because they are attempting to diet. Ideals

portrayed in the media are becoming thinner and therefore less achievable, which is likely to impact on an individual's self-esteem and sense of failure as they are unable to emulate these images.

Social learning theory (Bandura, 1977) suggests that in order to change behaviour, it is necessary to initially change predisposing factors such as environmental influences (e.g. media) personal factors (e.g. values and attitudes) and self-perceptions (e.g. body image), suggesting that the focus of thinness and beautiful women as successful and desirable should be toned down. Media regulation of this sort may be futile, however, as through the interplay of societal beliefs and media reinforcement the ideal has become part of Western cultural fabric and gender roles and cultural values take significant time to change. Dieting remains synonymous with success and is seen as a solution to many problems. It seems unlikely within a society of heightened focus on physical appearance and materialistic wealth that comparison will reduce, particularly with media setting the goal of an idealised lifestyle for people to aspire to. Mental health problems including low self-esteem, depression and eating disorders are therefore likely to continue.

Hamilton and Waller (1993) state that the presentation of 'idealised women' cannot be the only reason for body image overestimations. They suggest that for therapeutic reasons, it is a good idea for anorectic and bulimic women to avoid situations where women are presented in an idealised way, however in current

society, this would be practically impossible to accomplish. Media permeate every aspect of our lives. It is therefore of great importance that the role that media and other sociocultural factors play in eating disorders is better understood.

Although media play a role, they are not the only factors which influence eating disordered behaviour and it may be that the way in which a person relates to media (which maybe mediated by internal factors) is the predetermining issue.

Understanding variables that function as protective in relation to the sociocultural context of eating disorders increases our understanding of their development and maintenance (Heffernan, 1994), thus enabling treatment to be more effective. It is important for further research to be carried out in relation to the features influencing eating disordered behaviour so that we can continue to make improvements in this area.

There were a number of limitations within this study that may have impacted on the results obtained. Difficulties associated with the location of the interviews existed, whether these were at the client's home or in the eating disorder service. Within participants' homes often family members and other distracters such as telephones were present, possibly impacting on the participants' concentration and also the amount that participants were willing to say due to the risks of being overheard. Similarly, at the eating disorder service confidentiality and noise were issues and there was possibly an added difficulty for some participants as the room used was

the admissions room on the inpatient unit. This may have impacted on how comfortable participants felt and also how much they were willing to disclose.

It is also possible that the way in which the research was introduced and questions that were asked impacted on the interviews and the responses given. The initial question "Tell me about how your eating disorder developed" pathologises the individuals' problems and may therefore have influenced the way in which they answered the question. It was hoped that this influence was minimised by the open questioning. It was also thought that the impact of this line of questioning would have a limited impact because of participants ongoing contact with the eating disorder service, which in itself is likely to have led them to thinking about their difficulties in this way. The majority of eating disorders coverage within the media also pathologises difficulties so responses are likely to have been similar had the question been less pathological.

It is interesting to consider why the participants who took part in the research agreed to participate as although the results are believed to be well grounded in the experience of these individuals, it is possible that they are not representative of people with eating disorders as a whole and may have entered into the research with particular agendas, such as to better educate the general public. These issues were not addressed within this piece of research and may benefit from further investigation in the future.

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Chapter Three

The Stories that Women with Eating Disorders Tell About the Development of their Disorder: A Narrative Approach

Abstract

Objective: Narratives help people to organise their experience and give meaning to life-events. Narratives of women with eating disorders were examined to help understand how they make sense of their eating disorders.

Method: The participants were women with anorexia and bulimia nervosa from a local eating disorder service. Stories of how the women's eating disorders developed were obtained during semi-structured interviews and analysed using narrative techniques.

Results: The participants told progressive narratives that explained their early experiences, difficult life events and eating disorder development. All three participants attributed the cause of their disorder to external factors and described re-evaluating their sense-of-self in admitting that they had an eating disorder and during the process of therapy.

Discussion: Through re-evaluating their lives and reconstructing their stories, the women within this research had been able to move forward and overcome their eating disorders. The uses of narratives in therapy are discussed.

Narrative psychologists have argued that subjective experience may be represented in the form of an internal life story or narrative (Crossley, 2000). The analysis of life narratives may therefore illustrate what it means to undergo a particular experience. In this paper an analysis is conducted of the narratives that people with anorexia and bulimia tell about the development of their condition. It is hoped that this will give greater insight into the experiences and beliefs of individuals with these types of eating disorders.

Narratives

A narrative is a sequence of events structured with a beginning, middle and end, constructing a cohesive story (Dimaggio, Salvatore, Azzara, Catania, Semerari and Hermans, 2003; Murray, 2003). Narratives are malleable and are reconstructed as additional information is obtained. The defining feature of a narrative is that it joins events together in sequence, locating the events in time as well as space (Burr, 1995).

Narratives are important in understanding individual experience and provide meaning to a person's history by organising and assigning value or significance to events (Giles, 2003; Murray, 1999; Murray, 2000). Striving to find meaning in life is the primary motivational force in man (Frankl, 1984). Narratives enable people to make sense of their world, as well as to define themselves as individuals (Murray, 2003; Sacks, 1985). The stories that people tell are central to how they construct

their identity and the emphasis of narratives can imply a person's role within an event (Murray, 2003).

Stories can be used to either move the individual towards or away from their desired goal (Dimaggio et al, 2003). Gergen and Gergen (1984) cited in Murray (2003) describe three types of narrative, progressive (movement towards a goal), regressive (movement away from a goal) and stable (little change). The inability to develop a range of narratives to explain the world can lead to difficulties (Dimaggio et al, 2003) because people are unable to give meaning to their experience.

Narratives and ill health

During illness narratives become a particularly useful tool with which an individual can make sense of their experience (Frank, 1995). Illness gains meaning through the stories that people tell about it (Murray, 1999) and narrative is an everyday way of making sense of illness and the disruption that it causes to people's lives (Murray, 2003). During or following illness a person's identity is threatened (Murray, 2000). Narrative helps the person to reconstruct their identity and make sense of what has happened to them. "Life crises, such as the onset or diagnosis of an illness can become turning points when we begin to reassess whom we are and where we are going" (Murray, 1999, p48). Through the reconstruction of the stories that people tell about themselves, a sense of personal identity is maintained (Murray, 2000).

Dominant narratives within society also influence the way that people make sense of and explain stories about their experiences (Murray, 1999; 2003).

As well as being a form of self-care, narrative is a way in which a person can take some form of control over their illness (Murray, 2000). One function of narrative seems to be the removal of guilt by enabling the individual to extricate blame for what has happened.

In relation to eating disorders, Anderson (1990) described anorectics as expressing a fear of 'nothingness', a lack of identity without the disorder, suggesting that individuals had incorporated anorexia into their identity and life-story. Giles (2003) echoes this idea. "Sufferers' accounts of their eating disorder histories are woven into their life narratives to construct their identities as a particular type of anorexic or obese person" (p319). The meaning that individuals put onto their eating disorder and its role in their identity is likely to be important during therapy if change is to occur.

Eating disorders

People with eating disorders often struggle with whether their illness is beyond or within their control and the way in which they make sense of this illustrates how they perceive and give meaning to having the disorder. Narratives also highlight potential difficulties within therapy, for example by attributing an external cause to the illness,

accepting responsibility for improvement and recovery becomes more difficult (Stainton-Rogers, 2000). A person's recognition of a problem and decision to address it as treatable can be described as a 'turning point' because their self-perception changes (Crossley, 2000). This shift in identity (e.g. from being 'a thin person' to 'an anorectic') and a decision to change is likely to lead to the person having to reassess who they are and re-write their narrative accordingly.

As stated above, narratives are important in the way that people make sense of their worlds and illness and the resultant disruption gains meaning through narrative accounts. People with eating disorders have generally experienced stressful life events culminating in the development of their eating disorder. The sense that they make of this period of their lives and the narratives told about the development of their eating disorder is important in understanding the individual's subjective experience of their disorder and how this affects their sense of identity.

Design

This research was conducted with the assumption that, because the narratives were provided during 1:1 interviews, the external influence from the social context in which they were created was minimised. The narrative was therefore taken as an accurate representation of how the individual experienced the world and organised information, rather than having been created for the purposes of the interview.

The analysis aimed to examine the individual's life story, in relation to how their eating disorder developed, how participants integrated their eating disorder into their lives and how they gave it meaning. Key moments that people described within the development of their eating disorder, the style of the narrative and the impact that this had on the individual's identity were also examined. Common features and differences between participants' experiences were explored. This may be useful to clinicians working with people who have eating disorders because the narratives told by individuals help to illustrate how they organise and understand their experience as well as identifying unhelpful scripts.

The role of narrative therapy is to alter the dominant narrative that makes an experience problematic and to develop a new story that enables the person to function more effectively (Murray, 2000). Stories are the link between what goes on in therapy and what goes on in society (McLeod, 1997) and all therapeutic techniques enable clients to tell their story and to reframe and reconstruct their story so that they are able to live with them (McLeod, 1996). The understanding of how people see themselves in relation to their eating disorder is therefore important and the incidents and beliefs illustrated when people are recounting their narrative can be used within therapeutic practice to challenge distorted thinking or encourage change.

Method

Participants

The participants within this study were women suffering from anorexia and bulimia nervosa (n=3, ages 23, 31 and 35). Two of the participants were married with children whilst the other had recently ended a long-term relationship. All of the participants had been in therapy for a number of years and continued to receive support for their eating disorders. Narratives were obtained during 1:1 interviews, during which the women were asked to describe how their eating disorder developed. This question was part of a larger grounded theory study into eating disorders. The answer to this specific question elicited the stories of the women's eating disorders, which lent themselves well to separate narrative analysis. Transcripts from the first three participants recruited for the main study were used.

Ethical Considerations

Ethical approval for this study was obtained from Coventry University and from Warwickshire Local Research Ethics Committee (LREC) (See appendix E and appendix F respectively). For reasons of confidentiality, participants are referred to by randomly assigned names, alphabetised based on their position within the interviewing process. All potentially identifying information was removed from transcripts so as to protect identities.

Procedure

Participants were identified and approached as part of a larger study about eating disorders (See Chapter 2 for more details). The method used within the research was based on that described by Murray (2003). Two broad phases of narrative analysis were carried out. The first involved a descriptive summary of the transcriptions to determine the structure and content of the narratives so as to capture the overall meaning and any particular issues raised within each. The second step involved connecting the narratives with theoretical literature so as to interpret the story (Murray, 2003).

Analysis

Structure

All of the narratives followed the typical structure of a progressive story including a setting, the discovery of a problem and a journey resulting in the goal being (partially) achieved (Livingstone, 1998).

Claire and Alice's narratives were quite similar in that they described negative life events in the setting, with the eating disorder developing during the difficult period and becoming a means of coping. Alice and Claire both seemed motivated to continue striving in therapy and had made progress but still had work to do to reach the desired end. Claire stated

“I’ve sort of moved on quite a bit and still feel like I’ve got the final hurdle to get over...”

A positive outcome seemed achievable and the focus of both Claire and Alice’s efforts.

Belinda’s story was somehow less progressive, despite Belinda stating that she believed herself to be largely free from her anorexia. Belinda stated

“I think I’ve gotten well over it now as far as I won’t push it to the extreme again, you know I’d never be sort of eating like half biscuits a day or whatever, I mean I’ve got over that hurdle that, I will still watch what I eat and I will never ever be fat, because I wouldn’t let myself be, so its always going to be up there, no matter how many people cure you, but I don’t restrict myself, if I want to have like a McDonalds or chips, something I would never do before, I will do now, I might have a slimming pill afterwards, so it’s always there, but I do eat normally”.

Belinda seemed dissatisfied with the point that she had reached. There was a recurrent theme throughout Belinda’s narrative that the treatment she had received for her anorexia was not satisfactory; she viewed her treatment when she was a child negatively and thought that the treatment from the eating disorder service came too late (because of a waiting list) and was not strict enough to benefit her. Belinda therefore presented a somewhat stable picture of things being

unsatisfactory and with negative events throughout. Belinda seemed to have reached a plateau and did not appear motivated to move on from this stage. It is also visible from Belinda's quote that she externalised the progress that she had made, commenting that people 'cure you'. All three of the women seemed to attribute external causes to their eating disorders.

Explanation of cause

One function of narratives within illness seems to be removing guilt and enabling the person to explain the difficulty without feeling as though they are to blame (Murray, 2000). Alice's explanation for the development of her anorexia was that she began to vomit following the administration of an injection recommended by a doctor. A rare side effect resulted in Alice vomiting when she ate, which she said later became a habit and developed into an eating disorder. Alice also presented a vivid image of feeling trapped, with low self-esteem and being in an unsatisfying relationship preventing her from getting better.

"The best way I can describe myself was a butterfly in a jam jar with the lid screwed on and he quite happily put me in the jam jar and suppressed me and kept me there".

Alice illustrated the dilemma that Stainton-Rogers (2000) described in that, in contrast to her external attribution of cause, by acknowledging that she had the

ability to take control of the disorder and influence her future behaviour, Alice was taking a degree of responsibility for its development. Alice's narrative accounts for this by explaining that it was

“Uncontrollable within like the first 3 or 4 months when you know ...
because of the injection, it will take three months to get out of your system,
so by then it's already kind of a cycle and a habit as well isn't it...”

Alice seemed to be acknowledging that there was a change in the illness over time from a physiological reaction to a psychological, and therefore controllable, problem, however this shift was also described as subconscious and out of her control.

Alice seemed to preserve her sense of self by using the narrative to rectify these seemingly incongruent events.

Belinda and Claire also seemed to make sense of their eating disorders by relating them to difficulties earlier in their lives. Belinda described having used not eating and weight loss as a way of getting out of going to school. In this respect Belinda differed from the other participants because she seemed to have made a conscious decision to become unwell. The anorexia reoccurred on a number of occasions, however, and in subsequent episodes Belinda described making a decision to lose weight, but the dieting becoming out of control, leading to anorexia. This was similar to Claire's description as she also described difficulties in childhood and was in a

difficult relationship at the time of onset. For Claire the eating disorder started with dieting and the desire to lose weight, but led to vomiting after eating.

“I don’t even recall the very first time that the bulimia started or anything, you know I can’t even remember the very first time, but I think I just got into a pattern then of thinking ‘Well, I’ll have whatever I like tonight’ and then that’s when I started being sick”.

Claire added

“It sort of just happened, it’s just sort of... like I floated into it somehow”.

Again, the narrative suggests that the development of the eating disorder was beyond the sufferer’s control.

In externalising blame, the women could be trying to fight the social construct that anorexia and bulimia are primarily disorders of the self. Benveniste, Lecouteur and Hepworth (1999) state that the layperson’s view of anorexia is constructed as a dysfunction within the individual with the disorder. An individual with an eating disorder picking up on this viewpoint is therefore likely to feel the need to defend their position. An interesting point suggested by Giles (2003) is that medicalisation of eating disorders absolves the individual of any blame, however conflicting discourses around self-control remain. There is a conflict between the accounts that the individuals gave in that they do not accept blame for the eating disorder, but do see themselves as able to help themselves get better and choose to change. Claire

and Alice also described the eating disorder as enabling them to cope with difficult situations.

Coping strategy

Alice suggested that her eating disorder and problems with drugs were ways of coping with the problems of being in a difficult relationship and other difficult experiences such as her physical health problems, making sense of the disorder's maintenance.

Researcher: So, in someway the sort of things that you've described like the eating disorder now and the drugs before um, is like a way of getting out of that corner

Alice: Yep, absolutely... I knew what I was becoming. I didn't like it so I started taking far too many drugs and that obviously did not help the situation at home.

This explanation has a functional element and possibly makes the development and maintenance of the eating disorder more acceptable to people unfamiliar with such problems through its presentation as a coping mechanism. Claire also described her eating disorder as a way of coping with other difficulties in her life and a way of dealing with pressures that she found herself under during the day. Belinda's

explanation was different in that she did not state that her eating disorder was a coping mechanism, but described it as increasing her self esteem as she received comments from friends about the weight that she had lost. Each of these narratives illustrates the role of external factors in the sufferer's understanding of the maintenance of their disorder, although turning points were internally attributed.

Turning points

For all three of the participants, the turning points described seemed to be times when they had to re-evaluate who they were as individuals and what they wanted from life. Alice described the turning point within her life, and possibly also her anorexia, when she decided to take control and to leave the difficult relationship that she was in. What initiated the decision to leave was not disclosed.

“It got to the point where it was quite volatile and I thought ‘This isn't the way that I want to live my life’, you know, I'm not giving myself a fair chance with an eating disorder but I don't need that as well”.

Alice commented that up until that point she had been trying to please her partner, rather than considering herself. Within Belinda's narrative, she described having a baby as a turning point in her recovery and a chance to re-evaluate the situation.

"I think the baby, having the baby now is the best thing that could have happened to me, because it gives me another, you know, something to care for and not be so wrapped up in myself".

Claire's narrative seemed to suggest that a period of depression and the realisation that she was working herself too hard was a turning point for her. This also seems to be the point where Claire reevaluated her life and her identity, making sense of her difficulties with regards to the stress she was putting herself under.

"I can see... fit relaxation in, it's really important for my health, but it's weird doing that now because I think 'I would never give myself that time before', you know, I never saw it as important or as a priority, never did, you know, I thought that I should be working until 11 o'clock at night, which I usually was, either work, looking after the kids or sorting them out, or doing housework, ironing, on the computer, working right through to 11 o'clock at night, having about 5 hours sleep and then getting up and going to work again, you know, getting in to work at like 7 o'clock in the morning, covering all the early shift, working until 7 at night, you know coming home, an hour with my daughter, she'd go to bed, you know I'd feel really guilty about that because the amount of time that I spent with her is really minimal, it was nothing like I should... I look back now, I think 'God, I can't believe I did that', you know, its made me look at things really quite hard and think 'What

do I want... out of things?' you know, I can work, but its got to be a balance, and then I'm thinking I've got... I'd like to work and I want to work part-time because I've got 2 children, one's very young, well... 3, I've got a step-child... step-daughter as well".

Claire stopped seeing herself as having to do everything and as having to work full-time in a very demanding job; she reshaped her identity focusing on the importance of being a good mother and enjoying her time with her children and husband.

Summary of findings

The participants all told a narrative about the development of their eating disorder that made sense of their early experiences, difficult life-events and how they came to have an eating disorder. In the narratives of the three women interviewed, all had attributed the cause of their disorder to external factors beyond their control. Two participants seemed to have made a shift towards taking some responsibility for the disorder and their own recovery. All three of the participants had made progress within therapy and two seemed to accept responsibility for this improvement. The narratives of all three participants seemed to suggest that they had had to re-evaluate their lives and sense of self both in admitting that they had an eating disorder and during the process of therapy and change. This suggests that enabling people to re-write their story and make sense of their situation in different ways is helpful in overcoming an eating disorder.

Discussion

The results suggest that through re-evaluating their lives and reconstructing the narratives that they tell, the women within this research have been able to move forward and overcome their eating disorders. All of the women described a predominantly progressive narrative, presumably because of the positive changes that had come about through their experiences and work within therapy. It seems likely that had they yet to commence in therapy, the narratives may have been regressive. The lack of a final positive endpoint is possibly because the participants continued to receive therapy and so had not completely overcome their difficulties.

People with eating disorders appear to make sense of their disorders in similar ways, by externalising the cause and facing up to difficulties when external factors necessitated the person re-evaluating their life. Although this process has to begin before the person enters therapy to enable recognition of a problem, it is also likely that the process continues within therapy if the person is to make progress. By reframing and reconstructing their stories, people become more able to live with their experiences (McLeod, 1997). The participants seemed to preserve their sense of self by externalising the cause of the problems, then experiencing a shift where they were able to take some responsibility for change and improvement, although continuing to see the initial development as outside of their control. Narratives appear useful in enabling people to make sense of these conflicting beliefs in a way

that allows them to continue their life in a meaningful way. It is likely that work within therapy facilitates this process.

Stories are shaped by the social context in which they are constructed (Murray, 2000) and the participants' stories about their eating disorders were constructed within the context of a research interview. The participants' perception of the researcher may have been an important factor in the narratives told. Murray (2000) cites Radley and Billing (1996) who comment that researchers are usually assumed to be healthy, and that the ill person therefore may feel the need to justify their illness. This could have been important within these interviews because the interviewer was young and female, as were the participants. It is known that people with anorexia have a tendency to compare themselves to other people, and in making comparisons may have felt the need to justify their illness to the researcher, thus impacting on the narratives told.

Originally, social and community narratives regarding eating disorders were developed through conversations about an individual's experiences of the disorder and their treatment. "It is through the exchange of narrative accounts of particular illness episodes that a community develops a social representation of that illness" (Murray, 2000, p343). In modern society knowledge is primarily shared through the media. It is therefore important to consider the role that media now have in the development of these stories, as narratives are not constructed exclusively through

face-to-face conversations between people. Media have the power to reach a far greater number of people and to focus on a particular perspective of the disorder, thus influencing the societal narrative to a considerable degree. Conversations between people are likely to be directed by media messages to a greater or lesser degree. The dominance of certain perspectives regarding eating disorders is also likely to influence the position of people struggling with the disorder, and may lead to a defensive position being adopted and an alteration in their narratives to counter this dominant position. Investigation of how people with eating disorders believe other people see the disorder is therefore essential.

Future narrative studies into eating disorders would benefit from researchers eliciting more information about their life-stories without explicitly asking about the eating disorder. The interviews within this research were part of a larger study into the development of eating disorders. It was apparent through examining the transcripts that participants did not detail when they had decided that their eating habits had become a problem, how they decided to go about seeking help and important factors in implementing these changes. In hindsight this is likely to have been important in progressive narratives and may have been a trigger in the recovery from the eating disorder. It is interesting in itself that participants did not mention this as a factor within their narratives.

Further investigation into the narratives that people with eating disorders tell about themselves is important for a greater understanding of the subjective experience of eating disorders to be obtained, and to improve treatment practices in the future. If eating disorders do become central to the sufferer's sense of identity, it would be important to address this within therapy so as to enable the person to move forwards.

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Chapter Four

Reflections on the Research Process

This paper will primarily reflect on my experiences of the research process, particularly focusing on methodological and process issues.

Why grounded theory?

My interest in grounded theory started with an inspiring lecture where a clinical psychologist described her experience of using grounded theory for her thesis. I felt excited that the skills I have developed through my clinical work could be fused with research. I also loved the idea that new and novel information could be obtained using this method and that through systematic analysis of the data a theory could be developed to explain the participants' subjective experiences. I left the lecture enthused and more excited about embarking on the research project than I ever imagined I could be.

Part of what drew me to grounded theory was the structured methodology that enables the researcher to develop their theory, combined with the freedom of allowing the participant to decide what to say and where to take the interview. In reality the research process was more complicated than I had appreciated.

Doing grounded theory

Practicalities

I had anticipated that because I had chosen a clinical sample on which to carry out the research, recruiting participants would be challenging. I was right, however I believe that semi-structured interviewing made the women who did participate more enthusiastic about the interview because of their relative control.

The first hurdle that I had not anticipated was the nightmare of transcribing interviews. Although I knew that transcribing would be slow work, I had not realised how exhausting it would be. I discovered that bad recording quality was a particularly frustrating experience, however despite my best attempts to reduce background noise and improve the quality, I continued to struggle with this throughout the research.

I initially made the decision that I did not want to employ a professional transcriber because of the personal nature of the interviews and because I believed that I would have a better grasp of the data had I listened to it on numerous occasions before starting the analysis. I believe that this did help me to get closer to the data, and I had already made various notes and memos before starting to analyse the

transcripts. Despite the time and energy expended, I do not regret the days sat at the computer transcribing interviews.

Location of interviews

Another problem that I had overlooked was the complicating factors arising from interviewing people in their own homes. Although people seemed more relaxed and able to talk easily within the comfort of their own homes, I found distractions such as telephones ringing or family members hovering in nearby rooms challenging. I was particularly aware of confidentiality and that people might want to talk about sensitive issues but feel unable to speak freely with family members nearby. None of the participants identified this as a problem and I was similarly aware of noise and confidentiality issues in the room that I used within the eating disorder service.

Subjectivity

Part of the appeal but also part of my struggle with grounded theory was its subjective nature and that meanings are constructed from the data through the interaction between interviewer and participant (Charmaz, 2000). A further difficulty for me was that I have very high standards and can become quite anxious about my own abilities. Within qualitative methodologies there are no right and wrong answers, which I found quite difficult, and the chaos of grounded theory became apparent quite early on in the process.

There is a degree of unpredictability and lack of control within any research because participants may not respond to letters etc. however the abstract nature of qualitative methodologies and the lack of organisation and control were somewhat overwhelming at times, as was being completely submerged in the data. In many ways carrying out a grounded theory study is an isolating experience and it was a relief to have the other trainees from the grounded theory group to discuss this with because they were experiencing similar difficulties. A further problem of the grounded theory experience for me personally was that because I was so involved with the data, I no longer saw the theory I was developing as novel or exciting. It was the support and excitement of the grounded theory group that kept me enthusiastic about my research and their objectivity regarding the data that enabled me to get through the research process. This part of the experience was both enjoyable and invaluable.

Biases

From commencing the research, I was very aware of my preconceived ideas about eating disorders and biases about the media. Charmaz (1995) comments that researchers should avoid bringing their own perceptions into their analysis and Oskowitz and Meulenberg-Buskens (1997) also discuss the problems of researcher bias. I was concerned that my biases would influence the data and tried to address this by using memos to list my thoughts and prejudices before commencing the research. I also tried to control my prejudice, using the grounded theory group to

verify my analyses. Early in the research I was aware that I had possibly made more suggestions to participants than I would have liked to, particularly during the first interview, and quickly learnt that making suggestions reduced rather than expanded the breadth of data elicited.

On a personal level, I became aware, both from starting to hear the stories of people with eating disorders and later from reading the literature, that my own personal background was very similar to the experiences of some of the participants and of people with eating disorders generally. This may be where my interest in eating disorders stems from initially. My awareness of bias and the potential that I may be over-identifying and therefore influencing or misinterpreting data because of my own views concerned me, and I expressed these concerns to the grounded theory group and my supervisor so as to reduce the impact as much as possible.

The grounded theory group

As previously stated, the grounded theory group was both supportive and educative, however it was also challenging and anxiety provoking at times. Anxiety came both from a mutual sense of panic about the task at hand, but also from seeing others progress and move ahead at times when I felt stuck. Seeing others further behind was also difficult because I sometimes felt guilty for talking about my difficulties when other members had problems of their own. Within the group I learned to look after my own needs as well as being sensitive to others', and found a balance

between obtaining the support that I needed and simultaneously supporting other group members. The group was invaluable in this respect and a positive aspect of the research process. The challenges and questions asked by group members also helped to strengthen my understanding of my research by looking at it from alternative perspectives.

Eating disorders as a topic

It became apparent to me during my second year of training that I had actually chosen a topic area which might have been more difficult for me personally than I had imagined. At this time I was struggling in therapy with a blood phobia relating to self-harm. Reading literature about eating disorders, the link between anorexia and deliberate self-harm became increasingly clear and I realised that I had chosen a daunting group of participants. I am glad that I put myself in this challenging situation and believe that I have learnt a lot from the experience. Talking to people who harm themselves has helped me to build on the therapy I had to overcome my phobia.

Participant factors

Although I was aware of the possible impact of interviews on participants, I was not fully prepared for the emotion that was expressed by some of the women. It became clear during interviewing that for some of the participants, the experiences that they chose to describe were very intimate and distressing. I am very grateful to

the participants for being so open and honest with me, and for sharing such personal and emotional experiences with a relative stranger.

The stage in therapy of the participants seemed to impact hugely on the interview and information provided by participants. This could be because people in earlier stages of therapy had talked about their difficulties less, decreasing the amount that they had processed their problems. The information provided by women who were in the earlier stages of therapy seemed more spontaneous, raw and emotional compared to women who had received more therapy.

Despite the safe guards that I had put in place, I remained concerned about the impact of the research process on the participants. The isolation and desperation of some of the participants has remained with me. At the end of the interview one woman said that she felt like she had known me 'forever' and asked me to 'stay in touch'. I became more aware of how fragile some of the participants were and was more thorough in ensuring that they were okay at the end of the interviews and could talk to their therapist if needed. Support from my supervisors was essential in dealing with the emotional impact of the interviews and my concerns about the women involved. It was important for me to be aware of my own health and to look after myself during the interview process.

Personal reflections

Clearly carrying out a piece of research at this level is stressful, however at one stage I was also concerned about the impact of the subject matter on my health. In October I met someone I had not seen for six months and he commented that he did not recognise me because I had lost so much weight. This came as a complete shock to me and was very concerning because I had no intention of slimming. This incident made me more aware of what I was eating and making sure that I was not restricting my diet. I was also concerned that I may have been unconsciously trying to lose weight, which frightened me. I do not believe that this was the case, and I have since returned to my normal size, however I have remained conscious that I do not wish to develop any sort of eating abnormality. A recent experience on holiday has confirmed that food and weight gain is not an issue for me, which since commencing this research and the comments about my weight loss, I had started to question.

Since embarking on this research I am infinitely more aware of other people commenting on their own and others' weight, and how much of an issue and a focus appearance is within Western society. I more frequently notice how much people praise each other regarding weight loss and have become aware of advertising and diet products and the inappropriateness of some of these. I think this has made me less comfortable with the way in which society is evolving and more aware of the impact of media in my life.

Further research

None of women within this research mentioned their use of the internet, an increasingly influential branch of the media, or the pro-anorexia websites that exist. I purposefully did not mention either the internet or pro-anorexia to the women during interviewing because of the potential for participants to seek these out. I was aware that the damaging and competitive messages contained within these sites may reinforce participants' beliefs and therefore potentially negatively impact on the women's disorders. It is important for the influence of these websites and the extent of their use by people with eating disorders to be understood, as they could be a significant block to improvement within therapy. Further research to investigate the impact of these further seems an important area of the media in need of investigation.

Conclusions

Overall the experience of carrying out this research was very challenging but also hugely rewarding. I have particularly enjoyed exploring the participants' experiences with them, despite the occasionally difficult subject matter and emotional impact. At numerous stages during the research process, I have felt completely overwhelmed but at the same time have enjoyed the challenge and in many ways do not want the experience to end. For me, the end of the research process also signifies the end of clinical training, a period that I have enjoyed enormously. Conversely I feel as

though during training I have put life on hold and finishing the research, although anxiety provoking, also feels like the start of an exciting new chapter of my life. I am looking forward to facing the challenges that becoming a newly qualified clinical psychologist will bring!

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Appendices

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Appendix A: Information for Contributing Authors: 'European Eating Disorders Review'

Instructions to Authors

Initial Manuscript Submission. Submit four copies of the manuscript (including copies of tables and illustrations) to Dr Robert Palmer, University of Leicester, Brandon Mental Health Unit, Leicester General Hospital, Gwendolen Road, Leicester, LE5 4PW, UK.
Authors must also supply:

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Manuscript style. The language of the journal is English. All submissions including book reviews, must have a title, be printed on one side of the paper, be double-line spaced and have a margin of 3cm all round. Illustrations and tables must be printed on separate sheets, and not be incorporated into the text.

- The **title page** must list the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)**.
- Supply an **abstract** of up to 150 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
- Include up to five **keywords** that describe your paper for indexing purposes.

Reference style. The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication.

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited.

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary.

Example: In a 1989 article, Gould explains Darwin's most successful. . .

D. Specific citations of pages or chapters follow the year.

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears.

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al.* (meaning "and others").

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al.*, 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al.* in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author.

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text.

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows.

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

Journal Article

Murzynski, J., & Degelman, D. (1996). Body language of women and judgments of vulnerability to sexual assault. *Journal of Applied Social Psychology*, 26, 1617-1626.

Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

Book with More than One Author

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean*. Hartford, CT: University of Hartford Press.

Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world*. Hartford, CT: Capital Press. and so on.

The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials*. Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website:
http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796

Stand-alone Web Document (no date)

Nielsen, M. E. (n.d.). *Notable people in psychology of religion*. Retrieved August 3, 2001, from
<http://www.psywww.com/psyrelig/psyrelpr.htm>

Journal Article from Database

Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence*, 15, 503-522. Retrieved May 20, 2000, from ProQuest database.

Abstract from Secondary Database

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology*, 20, 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

Article or Chapter in an Edited Book

Shea, J. D. (1992). Religion and sexual adjustment. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 70-84). New York: Oxford University Press.

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The cost of printing **colour** illustrations will be charged to the author. There is a charge for printing colour illustrations of £700 per page. If colour illustrations are supplied electronically in either **TIFF** or **EPS** format, they may be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the *Wiley InterScience* site.

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Appendix B: Information for Contributing Authors: 'British Journal of Clinical Psychology'

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

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- Theoretical papers, provided that these are sufficiently related to the empirical data;
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications;
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1. Circulation

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2. Length

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The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

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Registered users: click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:

- Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author.
- Abstract
- Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

4) If you require further help in submitting your manuscript, please consult 'Tutorial for Authors' (PDF, 130Kb).

Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
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- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.
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Code of Conduct

Principles of Publishing

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- Tables, figures, captions placed at the end of the article or attached as separate files.

Appendix C: Information for Contributing Authors: 'International Journal of Eating Disorders'

Instructions to Authors

Disk Submission Instructions Wiley's Journal Styles and EndNote

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Manuscripts and all correspondence concerning manuscripts under review should be sent to the Editor-in-Chief, Michael Strober, Ph.D., Department of Psychiatry and Biobehavioral Sciences, UCLA Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, CA 90024.

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(2) Abstract (150 word maximum), should be started on a separate page, numbered 2. Type the word "Abstract" in upper and lower case letters, centered at the top of page 2. Authors of articles submitted to the Journal involving research data or reviews of the literature must now include the following information in the form of a structured abstract, under the headings indicated. The abstract should be typed as a single paragraph on one page: **Objective:** briefly indicate the primary purpose of the article, or major question addressed in the study. **Method:** indicate the sources of data, give brief overview of methodology, or, if review article, how the literature was searched and articles selected for discussion. For research based articles, this section should briefly note study design, how subjects were selected, and major outcome measures. **Results:** summarize the major or key findings. **Discussion:** indicate main clinical, theoretical, or research applications/implications. The Journal will continue to use unstructured abstracts for case reports.

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(5) Appendixes, each typed on a separate page labelled "Appendix" A, B, etc., in the order in which they are mentioned in the text.

(6) Footnotes, start on separate page.

(7) Tables, give title and start *each* on a separate page. If a table must be continued on a separate page, repeat all titles and headings.

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(9) Figures, place *each* on separate page.

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All manuscripts are subject to copyediting, although it is the primary responsibility of the authors to proofread thoroughly and insure correct spelling and punctuation, completeness and accuracy of references, clarity of expression, thoughtful construction of sentences, and legible appearance prior to the manuscript's submission. Preferred spelling follows *Webster's New Collegiate Dictionary* or *Webster's Third New International Dictionary*. The manuscript should conform to accepted English usage and syntax.

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In the body of text, be sure to indicate the position of each table by a clear break in text, with placement instructions set off by lines above and below.

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All reference citations in the text should appear in the reference list. The latter is arranged alphabetically by surname of authors; do not number. References by the same author with same publication date are arranged alphabetically by title (excluding *A* or *The*), and differentiated by lower case letters—*a*, *b*, *c*, etc.—placed immediately after the publication date. Each entry in the reference list must contain the surnames of *all* authors, full title of the work, the book or journal title in full (i.e., without abbreviation), year of publication, and inclusive page numbers (for journal articles and book chapters). Representative examples are as follows:

Dubowitz, H., Feigelman, S., & Reid, G. (1994). Children in kinship care: How do they fare? *Children and Youth Services Review*, 16, 85-106.

Baker, F.M., & Lightfoot, O.B. (1993). Psychiatric care of ethnic elders. In *Culture, ethnicity, and mental illness* (Volume 2, Chapter 12, pp. 517-552), Washington, DC: American Psychiatric Press.

Baker, F.M., & Lightfoot, O.B. (1993). Psychiatric care of ethnic elders. In A.C. Gaw (Ed.), *Culture, ethnicity, and mental illness* (pp. 517-552), Washington, DC: American Psychiatric Press.

McNeil, C.B., Eyberg, S., Eisenstadt, T.H., & Newcomb, K. (1997). Marital status and living arrangements. In W.W. Hartrup & Z. Rubin (Eds.), *APA Proceedings No. 512* (pp. 1-25), Washington, DC: American Psychiatric Press.

Preparation of figures. Figures should be professionally prepared and submitted in a form suitable for reproduction (camera-ready copy). Computer-generated graphs are acceptable only if they have been printed with a good quality laser printer. Graphs must show an appropriate grid scale. Each axis must be labeled with both the quantity measured and the unit of measurement. All figures and graphs must be photographed and submitted as 8 x 10 in. (20 x 25 cm) glossy prints, in triplicate.

All color figures will be reproduced in full color in the online edition of the journal at no cost to authors. Authors are requested to pay the cost of reproducing colour figures in print. Authors are encouraged to submit colour illustrations that highlight the text and convey essential scientific information. For best reproduction, bright, clear colours should be used. Dark colours against a dark background do not reproduce well; please place your colour images against a white background wherever possible. Please contact Jennifer English at 201-748-6644/jenglish@wiley.com for further information.

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Manuscripts are evaluated by one to three members of the Editorial Board, or outside reviewers selected by the Editor. Authors should anticipate a decision after a four to eight week period of review. If notice is not received by eight weeks, feel free to contact the Editor directly.

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Appendix D: Information for Contributing Authors: 'Clinical Psychology'

Clinical Psychology

Clinical Psychology is produced by the Division of Clinical Psychology of The British Psychological Society. It is edited by Lorraine Bell, Jonathan Calder, Lesley Cohen, Simon Gelsthorpe, Laura Golding, Henel Jones, Craig Newnes, Mark Rapley and Arlene Vetere, and circulated to all members of the Division monthly. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

Notes for Contributors

Articles of 1000-2000 words are welcomed. Send two copies of your contribution, typed and double-spaced. Contributors are asked to keep tables to a minimum, to ensure that all references are complete and accurate, and to give a word count. Please indicate the authors' employers, to appear at the head of the article, and include an address for correspondence, with email if possible. News of Branches and Special Groups is especially welcome.

Language. Contributors are asked to use language which is psychologically descriptive rather than medical and to avoid using devaluing terminology; i.e. avoid clustering terminology like "the elderly" or medical jargon like "person with schizophrenia". If you find yourself using quotation marks around words of dubious meaning, please use a different word.

Articles submitted to **Clinical Psychology** will be sent to members of the Editorial Collective for refereeing. They will then communicate directly with authors.

We reserve the right to shorten, amend and hold back copy if needed.

Copy

Please send all copy and correspondence to the Co-ordinating Editor: Craig Newnes, Field House, 1 Myddlewood, Myddle, Shrewsbury SY4 3RY; fax 01939 291209; e-mail: craignewnes@cs.com

DCP Update

Please send all copy to: Simon Gelsthorpe, CRST, Daisy Bank, 109 Duckworth Lane, Bradford BD9 6RL; email: hermanewtix@hotmail.com

Book Reviews

Please send all books and review requests to: Arlene Vetere, The Tavistock Centre, 120 Belsize Lane, London NW3 5BA

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Submitting to *Clinical Psychology*: A Checklist

- If sending hard copy, make sure it is double spaced, in a reasonably sized font and that all pages are numbered.
- Include a word count at the end (including references).
- Spell out all acronyms the first time they appear.
- Include the first names of all authors and give their employers, and remember to give a full postal address for correspondence.
- Give references in **Clinical Psychology** style, and if a reference is cited in the text make sure it is in the list at the end.
- Don't include tables and figures unless they save space or add to the article.
- Ask readers to request a copy of your questionnaire from you rather than include the whole of it in the article.
- Give a 20-word abstract at the beginning of the paper.

Appendix E: Coventry University Ethical Approval Form

COVENTRY UNIVERSITY - SCHOOL OF HEALTH AND SOCIAL SCIENCES
STUDENT SUBMISSION TO SCHOOL RESEARCH ETHICS COMMITTEE

1. Student's name: JILLIAN PETERS 2. Course: CLINICAL PSYCHOLOGY DOCTORATE
(BLOCK CAPITALS)
3. Title of project: THE ROLE OF MEDIA FIGURES IN THE DEVELOPMENT OF EATING DISORDERS: A GROUNDED THEORY APPROACH.
4. Summary of the project in jargon-free language and in not more than 120 words:

Sample: PEOPLE WITH A DIAGNOSIS OF ANOREXIA NERVOSA OR BULIMIA NERVOSA.

Research site: EATING DISORDER SERVICE/
HOMES OF PARTICIPANTS.

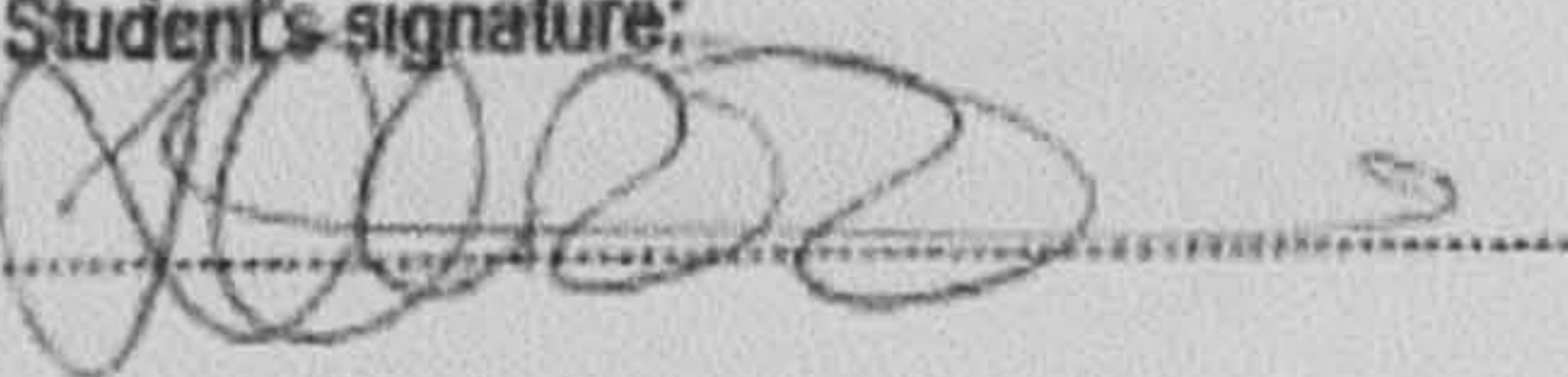
Design (eg experimental): QUALITATIVE (GROUNDED THEORY)

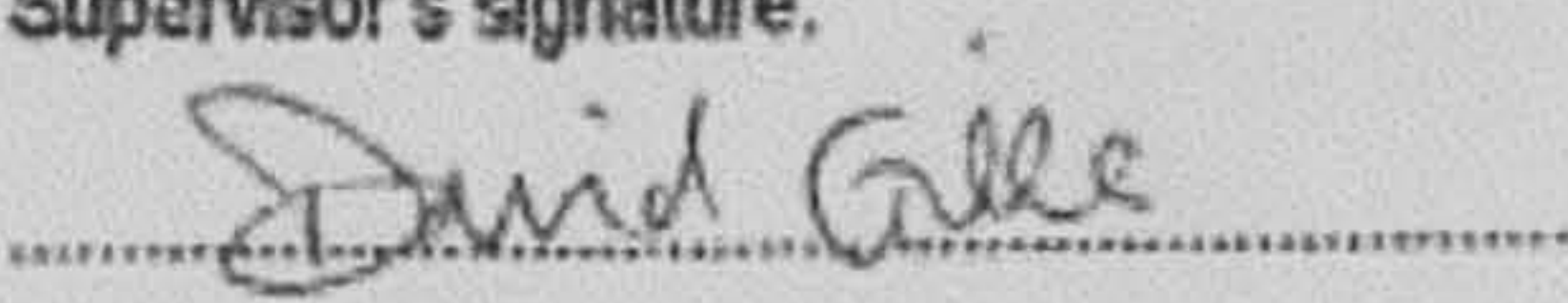
Methods of data collection: FOLLOWING INITIAL CONTACT MEETINGS TO EXPLAIN THE STRUCTURE & PURPOSE OF THE RESEARCH & OBTAIN CONSENT, DATA WILL BE COLLECTED USING SEMI-STRUCTURED INTERVIEWS. THESE WILL BE RECORDED ONTO AUDIO-CASSETTE SO AS TO ENABLE TRANSCRIPTION PRIOR TO ANALYSIS.

Access arrangements (if applicable):

VIA EATING DISORDER SERVICE.

- | | | |
|--|---|--|
| 5. Will the project involve patients(clients) and/or patient(client) data? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| 6. Will any invasive procedures be employed in the research? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 7. Is there a risk of physical discomfort to those taking part? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 8. Is there a risk of psychological distress to those taking part? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| 9. Will specific individuals or institutions (other than the University) be identifiable through data published or otherwise made available? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 10. Is it intended to seek informed consent from each participant (or from his or her parent or guardian)? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |

Student's signature: 

Supervisor's signature: 

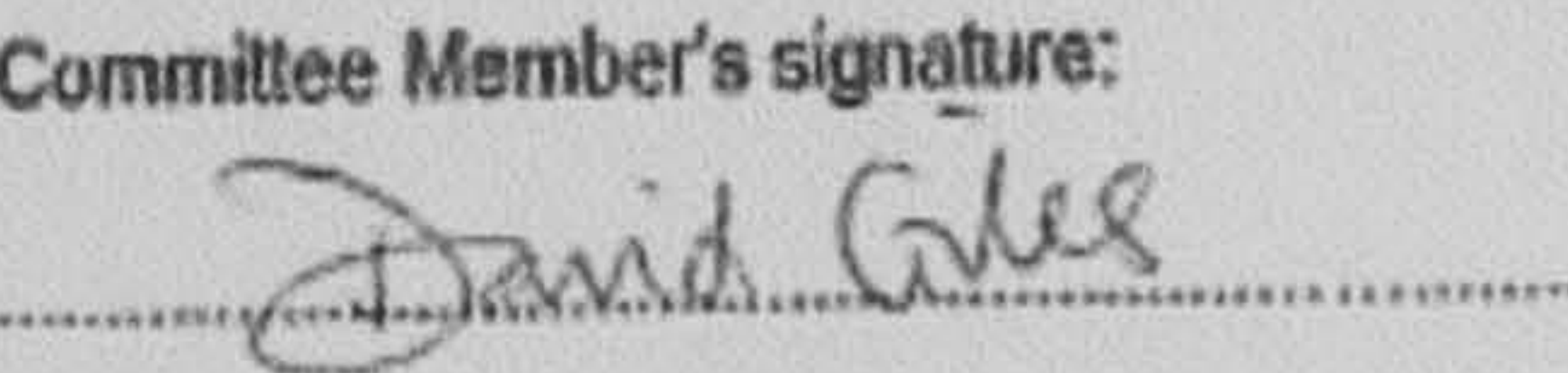
Date: 20/01/03

FOR COMMITTEE USE:

Immediate approval ☒
Referral to local Hospital Ethics Committee ☒

☒
☒

Referral to full School Committee ☐
Decision pending receipt of further information ☐
(specify below)

Committee Member's signature: 

Date: 20/01/03

Appendix F: Warwickshire Local Research Ethics Committee (LREC) Approval Letter



**West Midlands South Strategic Health Authority
(Including Coventry, Warwickshire, Herefordshire & Worcestershire)**

WARWICKSHIRE RESEARCH ETHICS COMMITTEE

**Lewes House,
George Eliot Hospital,
College Street,
Nuneaton
CV10 7DJ**

**Direct Line 02476 865244
Fax 02476 865058
E-Mail pat.horwell@geh.nhs.uk**

April 2003

Jillian Peters,

Warwickshire Local Research Ethics Committee
Approval Letter
(LREC-approved Study)


RE 564 The role of media figures in the development of eating disorders : A grounded theory approach

Dear Jillian,

I am pleased to advise you that your application to participate as a Local Investigator in the above RE-approved study was reviewed by the Warwickshire Research Ethics Committee at their meeting on 26th February 2003 has now been approved. The Committee works in accordance with ICH/GCP guidelines

Please quote our RE reference number and title in all correspondence.

Yours sincerely


Paul Hamilton (Chairman)

9/4/03
Date

Appendix G: Analytic Procedure

Procedure

Participants were initially contacted by their Care Co-ordinator from the Eating Disorder Service (See letter and information for participants, appendix L). On receipt of a reply slip, the researcher contacted participants and an initial meeting was arranged. If participants were still interested in participating following the initial meeting, a further appointment was made for the interview to take place. Interviews ranged from 40 minutes to approximately 3 hours duration.

Within grounded theory methodology there are three phases of data collection and analysis. Data was collected using semi-structured interviews. In the initial interviews, open sampling was used to gather enough information to begin coding (Giles, 2002), with general questions being asked to ascertain how the individual's eating disorder developed, their media use and general thoughts about how media featured in their life. All interviews were recorded and transcribed. Participants received copies of the transcriptions to ensure that they portrayed an accurate representation of the participant's views and to provide an opportunity for participants to alter what they had said.

As is central to the grounded theory approach, collection and analysis of data occurred simultaneously. Data obtained from the initial interviews was analysed and themes emerging from the data were used to focus and inform future interviews. This is termed relational sampling.

Validity and reliability

To address issues of reliability and validity, full documentation of the research process was detailed in extensive memos, tracking the researcher's train of thoughts and evidencing how data was organised into meaningful units (Giles, 2002). Memos ensure that the ideas used within the theory are grounded within the data obtained.

Theoretical sampling was also used to address validity and reliability by analysing new data (obtained from two further interviews) and ensuring that this fitted with the theory developed.

The researcher attended a qualitative research methods support-group for the duration of the research. This enabled the researcher to discuss the process of carrying out the research and concepts and theories emerging from the data. This also helped to reduce interviewer bias and ensure that the theory was grounded in the data. Other group members confirmed that they were able to see how categories and codes were devised from the transcripts and the reasoning behind the theory development.

References

Giles, D. (2002). *Advanced Research Methods in Psychology*. London: Routledge.

Appendix H: Open Coding

The initial analysis is called open coding and involved identifying themes and developing descriptive codes that encompass the meaning of the text. Coding began after the initial interview had been conducted (Charmaz, 1995) and was done on a line-by-line basis as far as possible with the view to avoiding the researcher prejudicing the information. Codes were kept as close to the text as possible and were often developed using the participants' words.

Line-by-line coding from Interview 1: Alice

Line	Transcription	Line-by-line code
59	I'm very aware of perceptions and the way people	Awareness how others see her
60	perceive or judgements that are made and I think that's got a lot to with it	Judgements/perceptions

References

Charmaz, K. (1995) Grounded Theory. In Smith, J; Harre, R and Van Langenhove, L. (Eds.) *Rethinking Methods in Psychology*. (pp. 27-49) London: Sage.

Appendix I: Focused coding

Once initial codes had been developed, the researcher then organised the codes into conceptual categories. Organisation of the data from the transcripts and the identification of themes and patterns were carried out manually as described by Pidgeon and Henwood (1997) so as to collect all of the examples found for each category together. Initial focused coding produced 23 lower order categories, containing varying numbers of codes. Some categories were merged because they seemed to relating to the same information. 36 lower order categories had been developed when the point of saturation was reached (See appendix M for list of lower order categories).

Lower order category and examples of comments made by participants

"Comparison"	lower order category
Belinda	"So that's why I link in to someone like Victoria Beckham, because she was how I used to be like, so that's, that's probably the only connection with me".
Claire	"Admittedly I've looked through magazines before and though 'Oh gosh, she looks really nice', you know 'Ooh, I wish I had legs like that'".
Diana	"They'll focus on like this little bit of cellulite or something on her thighs if it's an untouched photograph, so you think 'Oh God, well my legs are fatter than hers so I must have loads of cellulite'".
Elizabeth	"I always do that now, like when you walk down the street or (...), whoever you meet I'm always like "Are they thinner than me?" you know, that type of thing"
Gemma	"I think probably I've always compared with other people, everywhere, on television, in films and just people who I see"

Seven interviews were conducted during the open sampling and relational sampling phases of data collection where open and focused coding was carried out. At this point saturation was reached, no different ideas were being discovered within the texts and no further categories were being created. All new information examined fitted into the previously defined categories.

References

Pidgeon, N and Henwood, K. (1997) Using Grounded Theory in Psychological Research. In Hayes, N. (Ed.) *Doing Qualitative Analysis in Psychology*. (pp. 245-273) Hove: Psychology Press.

Appendix J: Axial Coding

During the next level of analysis, codes become “concepts rather than mere descriptions” (Giles, 2002, p172). The lower order categories were linked together where this seemed appropriate and conceptual links seemed to exist, creating higher order categories.

Higher order category and constituent lower order categories

Higher order category	Constituent lower order categories
Visibility	Judgements of others Importance of size/image Visibility Conformity Image portrayal Self image Acceptance/lovability

Final Analysis

Four of the lower order categories that had not been incorporated into higher order categories and which did not seem important in the final analysis were dropped at this stage. These were “Experience of the eating disorder” which was primarily made up of codes where participants had been talking about how difficult having an eating disorder was, “Familial Reactions” which related to the need for support family members of people with eating disorders, “Manifestations of other problems” where participants talked about other issues and problems that had led to the development of the eating disorder, for example physical or mental health problems and “Emotional reactions” where participants talked about emotions such as fear of gaining weight or worry about the future. Although these issues are all important in the general understanding of eating disordered behaviour, they did not appear to relate directly to the media, the research question primarily being examined.

During the final analysis stage, the theory was developed. The researcher identified the key higher order category that linked all of the others together. In this case, the key higher order category that linked all of the other categories and media together was ‘Conflict’.

References

Giles, D. (2002). *Advanced Research Methods in Psychology*. London: Routledge.

Appendix K: Reflective and analytic memos

Analytic memo:

Following interview with Diana 03.02.2004

Struck by similarity between what she said about media pressure, comparison and desire to look as celebrities present. Also struck by her desire to be 'perfect' and the best at EVERYTHING. Also echoes of interview with Belinda and desire to receive comments from others about how great she looks now that she has lost weight and the positive reinforcement from this, wanting to have this attention for self esteem, but in this interview the contrast of the repeated desire to fit in and be the same as everyone else – 'specialness and superiority' versus 'sameness and fitting in/acceptance'. Actually, she does not seem to want to fit in but wants to excel and be the best... (very limited circles where fitting in and being the best are complimentary – wants to only be part of these circles???)

Reflective memo:

Memo made following a research interview - 23.02.2004

Really difficult interview – a couple of times I felt like I was going to cry and at the end of the interview she looked so exhausted and drained that I wondered whether her taking part in the interview was a good idea. Spent quite some time at the end of the interview making sure that she was ok but was shocked when as I left she said that she felt like she'd known me 'forever' and also that she wanted me to stay in touch. Realisation how vulnerable and needy this particular woman is. Also felt as though using her for interviewing had been somewhat abusive, echoing her past experience. Must get some supervision about this both to make sure she is supported and because I'm exhausted and need to know that I haven't done any damage. I'm sure this interview experience will stay with me for along time.

Appendix L: Letter and Information Sent to Participants.

Dear (Participant)

I am writing to ask if you would be interested in taking part in some research investigating the role of media in the development of eating disorders. This service is keen to support research that may contribute to the knowledge and understanding of eating disorders. The research is being carried out by Jillian Peters (Trainee Clinical Psychologist) from Coventry University, in collaboration with Dr Wendy Phillips (Clinical Psychologist) and Dr Tony Winston (Consultant Psychiatrist) from the Eating Disorders Team.

The research will involve talking to the main researcher, Jillian, about your experiences of having an eating disorder, how your eating disorder developed and your experiences of the media. The interview is likely to take approximately one hour, and can be arranged for a time and place convenient to you. The interview will be recorded onto audiocassette so that the researcher can transcribe it, enabling analysis of the information to be carried out.

All the information that you give during the interview (and your personal details) will remain confidential at all times. The data collected (cassettes and transcripts) will not have your personal details or name on, to ensure that you cannot be identified. All of the data will be kept in a secure place. With your permission, your Consultant Psychiatrist and your GP will be informed that you are taking part in this study.

After analysis, the results of this research will be written up for publication. There will be no personally identifiable information in the published reports and you will be able to have a summary of the results should you wish. The Eating Disorders Service will also receive a summary of the findings but again there will be no personally identifiable information.

It is up to you whether or not to take part in this research. If you say yes, you will have the right to change your mind and withdraw your participation at any time. You will not have to give a reason. A decision not to take part, or to withdraw, will not have any effect on your treatment at the Eating Disorders Service or elsewhere.

If you are interested in taking part in the study, please return the reply slip on the adjoining page. Jillian will then contact you to arrange a time to meet and become acquainted, and to answer any questions or concerns that you may have about taking part in the study. A further meeting will then be arranged for the interview to take place.

Thank you for your time and I look forward to hearing from you soon.

Yours sincerely,

(Care Co-ordinator), Eating Disorder Service.

1. Study Title

The role of media in the development of eating disorders.

2. Invitation Paragraph.

You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take your time to decide whether or not you wish to take part. Thank you for taking the time to read this information.

3. What is the purpose of the study?

The purpose of the study is to find out more about eating disorders, and the factors involved in their development. More specifically, the study is investigating whether or not the media has a role in the development of eating disorders. This will include exploring the influence of thin female ideals as portrayed in the media, on the development of anorexia nervosa and bulimia nervosa. The relationships that anorectic and bulimic women have with the media and media figures, the role of cultural and familial beliefs in the development of eating disorders and any differences between the experiences of people with anorexia nervosa and bulimia nervosa will also be explored.

4. Why have I been chosen?

Participants, such as yourself, have been selected from the eating disorders service and are either currently receiving treatment for an eating disorder, or have received treatment in the past. All of the participants will be female and people who are currently inpatients will be excluded. All of the participants will also be over 18 years of age. Approximately 10 participants will be interviewed in total.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form. Even once you have signed the consent form, you are still free to withdraw from the study at any time, and without giving a reason. A decision to withdraw at any time or a decision not to take part will not affect the standard of care that you receive.

6. What will happen to me if I take part?

Participation in this study will involve being interviewed by the researcher (Jillian Peters, Trainee Clinical Psychologist) about your experiences of having an eating disorder, how this developed and your media interests and experiences. You will be able to choose where you would like this interview to take place e.g. at the eating disorder service or at home. This interview is anticipated to last approximately 1 hour, and will be cassette recorded so that the researcher can then transcribe the interviews, and analysis can be carried out. The researcher will then send you a copy of the transcription so that you can check that it accurately portrays what you said and so that you can alter anything that you would like to.

7. What do I have to do?

The research simply involves attending for an interview. You will not be required to do anything else.

8. What are the possible disadvantages and risks of talking part?

There are no likely disadvantages or risks to taking part in this study. If you are currently receiving treatment for your eating disorder, this will not be affected by taking part in the study.

It may, however, be that you find talking about some aspects of your eating disorder or its development distressing. If you are currently receiving treatment, then it is suggested that you should discuss your participation, and any issues that arise from taking part, with your therapist. If you are no longer receiving treatment but would like to talk to someone following your participation in the study, this support will be arranged through the eating disorder service.

9. What are the possible benefits of taking part?

We are hoping to gain greater understanding of eating disorders by carrying out this study, which, in the long term, may benefit people having treatment for eating disorders in the future. In the short term, there is no intended clinical benefit to you from taking part in this study.

10. What happens when the research study stops?

There will be no changes for you when the study is over. If your treatment for your eating disorder is ongoing, this will continue during and after your participation in the study.

11. What if something goes wrong?

If you have any cause to complain about any aspect of the way you have been approached or treated during the course of this study, the normal NHS complaints mechanisms are available to you. You may also contact the researcher's supervisors at the eating disorder service or at Coventry University should you wish to make a complaint (See separate contact details sheet).

12. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of this research will be kept strictly confidential. Any information that leaves the department will have your name and address etc. removed so that you cannot be recognised from it.

With your permission your Consultant Psychiatrist and your GP will be notified about your participation in the study, however they will not be informed of the content of the interview. The exception to this is if you talk about harming yourself or someone else, or a child in danger, in which case this information would NOT be kept confidential.

13. What will happen to the results of the study?

If you wish to receive a copy of the results of this study, please state this to the researcher and you will be sent a copy. When the study is complete, the results will also be sent for publication in academic journals. If you wish to be notified when these articles are accepted

for publication, this is possible. The research may also be sent for publication outside of the academic field. You will not be identified in any of the written reports or publications.

14. Who is organising and funding the research?

The research is being organised by a postgraduate student from the Universities of Coventry and Warwick, as part of her Doctorate in Clinical Psychology. Academic staff from Coventry University and clinical staff from the eating disorder service are supervising the study.

Your doctor or consultant is not being paid for including you in this study.

15. Who has reviewed this study?

Warwickshire Local Research Ethics Committee has reviewed this study.

16. Contact for further information.

Should you require further information, please do not hesitate to contact me at the following address.

Jillian Peters,
Trainee Clinical Psychologist,
Clinical Psychology Doctorate,
Coventry University,
Priory Street,
Coventry.
CV1 5FB

Thank you for your participation in this study.

REPLY SLIP

I am interested in taking part in the research project looking at the role of media in the development of eating disorders

I am happy for you to contact me so that we can arrange a meeting.

I can be contacted at (phone number or address):

.....

Name:

Signed

[Please give details below if you have any preferences as to when I contact you]

(to be returned to Jillian Peters at the Eating Disorders Service)

CONSENT FORM.

The role of media in the development of eating disorders.

I (Participant) have had the nature and purpose of this piece of research explained to me.

Yes

No

I understand that my personal details and any information that I give during the research will remain confidential and will be kept securely.

Yes

No

I am aware that I can withdraw my participation from the study at any time and that I will suffer no negative consequences as a result of this withdrawal.

Yes

No

I have had an opportunity to discuss with the researcher any questions or concerns I have regarding the research and my participation.

Yes

No

I am aware of how to make a complaint about the researcher or study should I wish to do so.

Yes

No

I wish to participate in this study.

Yes

No

I agree that my Doctor should be contacted and told that I am taking part in this research.

Yes

No

Signed:

Date:

Appendix M: List of Lower Order Categories

1. Incomprehensible
2. Visibility
3. Change
4. Interest in people
5. Self sacrifice
6. Manifestation of other issues
7. Lack of control
8. Emotional reactions
9. Self image
10. Comparison
11. Conformity
12. Health
13. Conflict
14. Judgements of others
15. Modern society
16. Image portrayal
17. Reactions
18. Beliefs (irrational)
19. External pressures
20. Influence/power
21. Experience of eating disorders
22. Shortcomings of the media
23. Goals (aspirations)
24. Deception
25. Loss
26. Isolation
27. Extremity
28. Irrationality
29. Education re food/diet
30. Involvement/fascination with food
31. Confusion
32. Escapism
33. Acceptance/lovability
34. Competitiveness
35. Importance of size/image
36. Dissatisfaction/(self)criticism